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FACE PAGE FORM PHS 5161-1

VERMONT INTEGRATED SERVICES PROJECT
ABSTRACT

Vermont Governor James Douglas has instructed the Vermont Department of Health to improve Vermont's capacity to provide effective treatment for individuals with co-occurring substance and mental health disorders. Gov. Douglas, in applying for this State Incentive Grant, has directed that the state will use evidence-based practices for outpatient client populations. Vermont will employ the Comprehensive, Continuous, Integrated System of Care framework to organize the systems change at the state and local program levels. The project will focus on quadrants two and three of the four quadrant State Director's Conceptual Planning Framework.

The Vermont Integrated Services Project will focus on the publicly funded outpatient behavioral health treatment systems operated by the State's Mental Health Authority (DMH) and the Alcohol and Substance Abuse Authority (ADAP). As of July 1, 2004, both ADAP and DMH will be located in the Vermont Department of Health, a reorganization that recognizes the common links of these two agencies. The project will also include Vermont's two Federally Qualified Health Center primary health care agencies.

The Vermont Integrated Services Project will focus on the following infrastructure development goals. ADAP and DMH will create the expectation, and provide requisite supports, to ensure that service providers *screen* for both mental and substance use disorders and perform integrated *assessments* to understand the course, severity, and interaction of co-occurring disorders on an individual in order to plan appropriate treatment. We will *train* local clinical and administrative leaders on the principles and practices of integrated treatment using evidence-based approaches to prevention, intervention, screening, assessment, treatment, and recovery services. ADAP and DMH will create a state-level management group tasked to re-design our respective Information and Business systems to fund, contract for, and evaluate integrated treatment services through *information sharing and financial planning*. We will use an organized, systems change framework to sequentially guide our work at both the local service and state levels. The implementation process for the Vermont Integrated Services Project will be evaluated using a quality improvement approach allowing rapid feedback and adjustments to implementation. In addition, we will use the performance measures adopted by the National Associations of State Alcohol and Drug Abuse and Mental Health Program Directors.

Table of Contents

BUDGET FORM (STANDARD FORM 424A)

PROGRAM NARRATIVE AND SUPPORTING DOCUMENTATION
SECTION A – DOCUMENTATION OF NEED/PROPOSED APPROACH

A1. Current System and Proposed Activities for the Vermont Integrated Services Project

Introduction

The office of the Governor is the applicant for this SAMHSA Grant, and Governor James Douglas of Vermont has signed this application. Governor Douglas has appointed the Vermont Department of Health (VDH) to be the lead department for this grant project, and he and members of his staff will work with the VDH to implement the activities described in this narrative. As of July 1, 2004, Vermont's State Mental Health Authority (DMH), and the Substance Abuse Authority (ADAP) will both be organizationally housed in the Vermont Department of Health. Developing adequate treatment services for substance abuse disorders, as well as co-occurring disorders, is a priority of the Douglas administration. Governor Douglas has demonstrated this leadership by 1) instituting his DETER Program which includes legislative and budget changes in support of substance abuse treatment programs, 2) charging specific staff to lead Vermont's co-occurring treatment initiatives, and 3) closely tracking the progress of developing integrated treatment in Vermont via a detailed weekly update.

The State of Vermont proposes to use the COSIG grant program to develop its capacity to provide accessible, comprehensive, integrated and evidence-based treatment services to individuals with co-occurring substance and mental health disorders and their families. The project will develop this capacity by focusing on the following goals: *screening* and *assessment*, *training* for key clinical and programmatic leaders, and, at the state level, *financial planning* and *information sharing*. The project will involve the public adult outpatient and emergency behavioral health treatment systems operated by the Division of Mental Health (DMH) and the Division of Alcohol and Drug Abuse Programs (ADAP). We will use a systems change framework called the Comprehensive, Continuous, Integrated System of Care model to organize our work at the state and program levels and rely on the guidance provided by SAMHSA's Treatment Improvement Protocol, "Substance Abuse Treatment for People with Co-occurring Disorders". Vermont is already piloting the use of the "Integrated Dual Disorders Implementation Resource Kit" through a separate SAMHSA grant (see below). The Divisions of ADAP and DMH will create a management team to consolidate the Information and Business systems of the two agencies involved as these relate to the development of integrated treatment services. The evaluation for the Vermont Integrated Services Project will have four components. First, Vermont will track the progress and process of the project implementation using a grant activities tracking system, and regular data reports to stakeholders. Vermont will monitor the development of services capacity using a CCSISC system assessment tool called the COFIT (see Appendix 3), on-site program reviews and clinical chart audits. Vermont will assess the impact of services development on clients by monitoring employment rates, arrest rates, and increased economic independence before and after treatment. Finally, Vermont will use the co-occurring disorders performance measures adopted by the National Associations of State Alcohol and Drug Abuse and Mental Health Program Directors.

Co-occurring Substance and Mental Disorders: Prevalence and Problem

In the early 1980's the co-occurrence of substance abuse and severe mental disorder emerged as a public health concern (1). Researchers observed that substance abuse disorders were relatively common among people with serious mental illness (2). The Epidemiologic Catchment

Area (ECA) Survey (3) and the National Co morbidity Survey (4) revealed high prevalence rates for co-occurring mental and substance use disorders in the general population. Nearly 43% of individuals with an alcohol or substance abuse disorder in a year also had at least one diagnosable psychiatric disorder in the same year (4). Similarly, almost 15% of individuals with a psychiatric disorder in a given year also had an addictive disorder (4). Yet, while co-occurring disorders were relatively common, researchers observed that treatment systems were not effective in working with both disorders together (5).

There is strong evidence that the interaction of both disorders exacerbates negative outcomes associated with either disorder. Compared with individuals who have a single diagnosis, individuals with co-occurring disorders generally do not respond as well to standard treatments (6), are hospitalized more frequently (7), are more frequently homeless (8), have a higher frequency of violence (9, 10) and are incarcerated more often (11). Drake & Brunette (12) also report that these individuals show higher rates of medication non-compliance, suicide, financial strain, family difficulties, HIV risk behaviors and legal problems.

Co-occurring Substance and Mental Disorders Treatment Systems: State of the Art

While the etiology of co-occurring disorders is still debated, there is an emerging consensus about the principles of effective treatment and the necessary characteristics of service systems to carry these out. This consensus can be summarized as follows. When mental and alcohol or substance abuse disorders co-occur, both disorders should be considered primary, and each disorder should be treated with the best available mental health and substance abuse treatment technology. Treatment for both disorders is most effective when provided simultaneously, rather than sequentially, and in a coordinated fashion. In addition, the greater the severity of the illness the more critical it is that treatment be integrated by a single team. Finally, it is not necessary to create separate systems of care for people with co-occurring disorders; rather existing treatment systems can become capable of providing consultative, collaborative and integrated treatment appropriate to the population already being served (17-23). Vermont's vision for a state-of-the-art system is built on these principles:

1. *Co-occurring disorders are common among people served by behavioral health systems and therefore should be expected.* Vermont's treatment systems need to orient itself in accordance with this expectation. Funding streams, programs, clinical practices, and clinician competencies must be designed to welcome, identify, assess, and address co-occurring disorders in each component of the system.
2. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated, diagnosis-specific treatment is recommended.* Evidence-based practice indicates that treatment is most effective when both disorders are considered primary and when treatment for one is integrated with treatment for the other. We need to develop specific practice guidelines emphasizing how to integrate clinically appropriate, diagnosis-specific best practice treatments for multiple disorders for clients within each service setting.
3. *People with co-occurring disorders do not constitute a single population but, rather, are heterogeneous. Therefore, there is no single intervention or program for Co-Occurring Disorders Treatment.* As described in the "Four Quadrant" framework, substance and mental disorders are spectrum disorders that vary from mild to severe (23). The primary locus of treatment (substance abuse providers, mental health providers) will vary, as will the degree of services integration (consultation, coordination, integration) depending on the severity of each

illness (23). Therefore, while each program within Vermont's behavioral health treatment system must be capable of identifying and treating co-occurring disorders, each program needs to have different characteristics in terms of level of care (intensiveness), role in the system (episodic or ongoing care), particular client population served, and scope of practice (specialty or general). In addition, services need to be designed to meet the needs of those special populations (e.g. women, the elderly) and ethnic minorities that are part of the heterogeneous group of persons in need of integrated services. Demonstration programs on integrated treatment and cultural diversity have found that cultural sensitivity and competence are critical to engaging individuals in dual disorder services (24). Culturally sensitive services must take into account the different help-seeking patterns of diverse groups, as well as the cultural meaning these groups assign to mental health and substance abuse services. A lack of sensitivity often creates additional barriers that further limit access to integrated services.

Current Structures

Vermont's Mental Health Authority, the Division of Mental Health (DMH) directly operates the Vermont State Hospital (VSH) and contracts with 10 private, nonprofit designated agencies (DAs) to provide comprehensive treatment and rehabilitation services across the state. These services include community support programs for adults with severe and persistent mental illnesses (SPMI), emergency services for people in mental health crises, outpatient services for adults seeking mental health treatment for behavioral and emotional difficulties, and comprehensive treatment and support services for children and adolescents who are either experiencing a severe emotional disturbance or are at substantial risk for developing a severe emotional disturbance. Under a reorganization plan approved by the Vermont Legislature, the Division of Mental Health will join the Vermont Department of Health as of July 1, 2004. A newly created position, Deputy Commissioner of Mental Health will report directly to the Commissioner of Health.

The Division of Alcohol and Drug Abuse Programs (ADAP) acts as the State Substance Abuse Authority and it is part of the Department of Health. ADAP has statutory authority to plan, operate and evaluate substance abuse programs throughout the state. ADAP is responsible for prevention services, project CRASH (for individuals convicted of DUI offenses), and alcohol and drug treatment services. ADAP provides funding to treatment programs in 32 locations in the state. Treatment programs provide a variety of services including public inebriate, outpatient, intensive outpatient, residential, transitional [halfway] houses, case management services, and recovery services. Under the direction of the Commissioner of Health, ADAP reviews and approves all alcohol and drug programs developed or administered by any state agency or department, excepting those developed by the Department of Education. ADAP also provides monitoring, evaluation and quality assurance services to treatment and prevention programs. ADAP conducts surveys to determine the prevalence of substance abuse risk factors and treatment needs of communities and provides training and technical assistance to substance abuse programs and professionals throughout the state. A newly created position, Deputy Commissioner of Alcohol and Drug Abuse Programs will report directly to the Commissioner of Health.

Both DMH and ADAP contract with many of the same local treatment providers. Nine of the ten Designated Agencies (DAs) that DMH contracts for mental health services also contract with ADAP to provide substance abuse treatment. Approximately two thirds of the clients receiving substance abuse outpatient and intensive outpatient treatment services in Vermont receive those

services in the DA system. Despite this, mental health and substance abuse programs under the same DA tend to operate separately, interacting more with the respective state MHA or SSA than with their sister DA programs.

Co-Occurring Management Structures

The ADAP and DMH Division Directors each appointed one point person to lead Vermont's integrated treatment initiatives, Beth Tanzman (DMH) and Linda Piasecki (ADAP), in January 2003. Together they have worked to create and staff a multi-stakeholder planning group, called the State Policy and Operations Team for Co-Occurring Disorders (SPOT). The SPOT has met five times and has identified several critical barriers to providing integrated treatment from consumer, family, service provider and advocate point of views. There is no dedicated staff time within ADAP to focus on co-occurring disorders. DMH does dedicate staff time (2 FTEs plus weekly management team support) for the integrated services project for adults with severe and persistent mental illness through a SAMHSA-funded Evidence Based Practice (EBP) Training and Evaluation Grant on dual disorders treatment.

In the face of several initiatives to develop integrated treatment, it has become clear that a critical first step is to create a management decision-making group representing both ADAP and DMH for the development of integrated treatment systems. In lieu of such a structure, Vermont will continue to identify barriers to integrated treatment without being able to re-deploy resources, evolve policies, and address the considerable barriers to integrated treatment in our respective fiscal, information, and clinical systems. This project proposes to create an internal management team within the Department of Health authorized to make changes in ADAP and DMH's administrative, clinical, and fiscal practices as they relate to integrated treatment for co-occurring disorders.

Project Goals and Infrastructure Development

To fulfill Vermont's vision for a state-of-the-art system, the Vermont Integrated Services project will use COSIG funds to focus on the following infrastructure development goals: *screening* and *assessment*, *financial planning*, and *information sharing*. We will use a comprehensive *training* program and the project's milestone evaluation approach to help build our system's capacity to meet these goals. The capacity building methods and the infrastructure development goals will be linked using a structured framework for systems change called the Comprehensive, Continuous Integrated System of Care (CCISC). The project will primarily focus on Vermont's adult outpatient behavioral health treatment systems and our two Federally Qualified Health Centers and will involve other partners such as DA emergency programs, Corrections, inpatient services, and substance abuse residential providers at the points where these services intersect with the adult outpatient behavioral health treatment system at the Designated Agencies. There are many shared clients. Vermont's Medicaid Agency currently delegates policy, administrative, and program authority to DMH and ADAP. The Department of Health will be the lead agency on the project. Vermont has secured letters of support/commitment to participate in this project from each of these participating prevention and treatment organizations (see Appendix 1).

These treatment providers included in this project span all four of the Quadrants as detailed by NASMHPD and NASADAD (23), however, this project will focus primarily on Quadrant Two and Three services. Specifically, the service providers from Quadrant One are the primary health care providers (FQHCs), and the emergency programs of the DAs. Quadrants Two and

Three are represented by the Designated Agency network and the contracted ADAP service providers. Quadrant Four is represented by the intensive DA Community Support Programs for people with severe and persistent mental illness and substance abuse/dependence disorders.

Screening and Assessment

Current Status

Neither ADAP nor DMH currently require their adult outpatient contracted providers to universally screen and assess for both mental and substance use disorders at VDH treatment sites. As a result most service providers simply perform *either* substance abuse *or* mental health assessments as part of the process of providing treatment. Vermont data indicates that we do not identify or treat co-occurring disorders at the expected prevalence rates for these disorders. There is no single data system at the state level to which screening results can be reported, consequently, at the state level, we lack information about the occurrence of both disorders to guide the development of enhanced resources.

Baseline

The Vermont Department of Health has employed two key strategies to develop data. The first strategy is client-level service encounter data that we collect from service providers each month: the Monthly Service Report (MSR) for the Division of Mental Health and the Substance Abuse Treatment Information System operated by the Division of Alcohol and Substance Abuse Programs. The second strategy links existing databases from other State Departments and programs. So, to establish a baseline of the reported prevalence of co-occurring disorders, we use Mental Health's MSR, Medicaid claims data, the Hospital Discharge Data set, and criminal justice data. Based on the state's population of people aged 12 and older, we estimate that *39,060 Vermonters have co-occurring disorders* (13, 14). Extrapolating the estimated prevalence of co-occurring disorders in Vermont to the Medicaid-enrolled population (160,000 individuals in FY 2002) indicates that roughly 10,250 Vermonters covered by Medicaid could be expected to have co-occurring mental and substance abuse disorders. An analysis of Vermont's Medicaid Data Base shows that only 2,292 individuals (1.3% of Medicaid enrollees) received services under both mental health and substance abuse diagnoses. While the cost of Medicaid-reimbursed community based behavioral health care in FY 2002 approached $146 million, less than $17 million (12%) supported services to people with co-occurring disorders (15).

While there is relatively little Medicaid-reimbursed *outpatient* care provided for people with co-occurring disorders, an analysis of Vermont's Hospital Discharge Data Set indicates that we pay a high price for *inpatient* care for people with co-occurring disorders. In calendar year 2000 more than one third of all inpatient admissions for behavioral health care were for people with both mental and substance abuse diagnoses (16). The total cost of inpatient behavioral health care by all payers provided to Vermont residents in 2000 approached $45 million and people with co-occurring diagnoses accounted for $14 million of this total. The total cost of inpatient behavioral health care provided to individuals covered by Medicaid and/or Medicare approached $20 million and individuals who had both substance abuse and mental disorders accounted for $4.8 million of that total (16). Almost 60% of all involuntary admissions to Vermont's only state hospital list recent drug and or alcohol use in addition to mental disorders as contributing factors to admission. These admissions cost Vermont over $5 million a year. In summary, Vermont is spending nearly $10 million in public funds on inpatient care for people with co-occurring

disorders. Integrated outpatient treatment services show promise for providing more appropriate care and for significantly reducing these costs.

The DMH's information system (MSR) records the existence of co-occurring disorders via three indicators: diagnosis (multiple diagnoses on each axis can be reported), a problem assessment at intake, and the receipt of substance abuse services at a DA. Using these three indicators, one third (33%) of all clients in the SPMI programs during CY 2003 had a co-occurring substance abuse disorder. In addition, almost one fourth (24%) of recipients of adult outpatient mental health services had a co-occurring substance abuse disorder. The current ADAP Substance Abuse Treatment Information system includes no indicators of mental health problems; so requisite data systems and reporting requirements need to be created in order for ADAP to report on the co-occurring performance measures.

The primary care treatment system, especially Vermont's Federally Qualified Health Centers, do regularly screen for both mental or substance use disorders. However, there are few referral agreements between primary care and the specialty behavioral health systems. Consequently, individuals who screen positive for both disorders and whose needs exceed the capacities of primary care may not receive comprehensive assessment and integrated treatment. No information system currently captures the screening results of people served by a FQHC.

Proposed Infrastructure Changes

Vermont will use the COSIG funds to develop a universal protocols for screening and assessment of co-occurring disorders at each adult outpatient DA treatment site and at the two Federally Qualified Health Centers. The results of assessments will be reported to a uniform data system which in turn will be used to report on co-occurring performance measures, to help target resource and program development, and to inform quality management and improvement activities. We will accomplish the infrastructure development goal of universal screening and assessment through redesign of our contracting process with service providers, selection of a narrow set of valid screening and assessment tools (e.g. GAIN), integration of data systems to support the development and reporting of co-occurring performance measures, and a comprehensive joint training program for service providers. Over the course of the project, we expect that our rates of diagnoses of co-occurring disorders in the mental health outpatient programs will increase from the current baseline of 24% by 10% per year to at least 50%, which is more in line with the expected rates of diagnosis for both disorders at a point in time (as opposed to life-time prevalence). In the case of substance abuse outpatient programs, we expect that the rates of reporting diagnoses of co-occurring disorders will increase 10% per year from the current zero to roughly 40% of individuals served. In addition, we expect that 100% of the DA adult outpatient substance abuse and mental health programs will screen for co-occurring disorders, complete assessments on those clients who screen positive, create treatment plans that reflect the best practices for both disorders, and demonstrate co-occurring treatment capability within programs. We will assess this jointly conducting program reviews and chart audits, and by programs' own self assessments using a CCISC program assessment tool called the COMPASS (see Appendix 3). In addition, we expect to increase the collaboration among DA mental health and substance abuse providers and with the FQHCs for case consultation, collaboration, and in some instances, integrated treatment. We will demonstrate this system collaboration by increasing the number of Medicaid recipients who received both substance abuse and mental health services in a year from the current baseline of 1.3% to at least 10%.

Finally, we will assess the impact of our treatment systems on client outcomes by tracking rates of employment, rates of arrest, and economic self-sufficiency before and after treatment.

The goals of this project include increasing the validity, reliability, and completeness with which individuals with co-occurring mental health and substance abuse disorders are identified in existing databases, expanding the tools used in this decision making process, and integrating the results of these analyses into the existing information systems. The results of these assessments will be shared with stakeholders (service providers, program administrators, consumers, and other interested parties) in order to encourage the use of these indicators in program administration, resource development, and to help improve the quality of the data. Most important, the results of these assessments will be integrated with outcome measures in order to provide a more complete evaluation of program performance in identifying and treating co-occurring disorders. Consistent reporting of these measures will help to insure that the behavioral health system sustains its efforts towards integrated treatment, as any changes in outcome will raise the attention of all of our stakeholder groups.

Financial Planning and Information Sharing

Current Status

ADAP and DMH currently fund and contract for adult outpatient behavioral health services completely independently of each other - even though we contract with the same local service provider agencies (DAs). We do not share a management structure to facilitate joint financial planning for integrated treatment services. Our respective payment mechanisms and rate setting processes are entirely different as are the fiscal management and understanding of administrative structural needs for the provider network. DMH receives monthly financial statements from the DAs for *all* programs and works actively with each of the ten DAs to assure their financial viability. ADAP requests an annual audited financial statement and quarterly reports but contracts for specific services. We each develop annual performance-based contracts with the same providers using entirely different processes and requirements. This arrangement is appropriate when we contract for discrete services but creates significant administrative barriers to the provision of integrated services at the local DA level.

Like our business systems, the ADAP and DMH information systems have developed independently of each other over the past five years. Designated Agency outpatient substance abuse providers currently report client level service encounter data via the MSR to DMH *and* they also report service-level data to ADAP via the Substance Abuse Treatment Information system. Our shared service provider network would appreciate a more unified and efficient approach to reporting. In addition, the analytical and reporting capabilities of our respective divisions are entirely separate so we make only very limited efforts at information sharing; and when we do so it is usually for ad hoc rather than ongoing management purposes. Preliminary discussions about a more unified approach to information systems evoke anxiety from each Division that key management and outcomes information would be lost (especially vis a vis Block Grant reporting requirements) and concerns that sharing Information System (SI) resources would further erode what seems to already be a too limited analytical and reporting capability.

Proposed Infrastructure Changes

We propose to improve the efficiency of our respective administrative procedures and to improve services in the context of this project and the reorganization of our respective divisions into the same department under the leadership of a single commissioner. Specifically, for *information sharing* we propose to develop common reporting and analytical structures including shared staff. ADAP and DMH will develop a common approach to developing and reporting on the SAMHSA co-occurring performance measures. We will share regular reports from our respective information systems. These reports will include: the identification of clients with co-occurring disorders in our treatment systems, encounter data showing the amount and types of services these clients receive, and outcomes reports to track the impact of treatment. In addition, we will assess the practicality of maintaining dual information systems. The internal management team will use these reports to guide system development.

In the area of *financial planning* we propose to use COSIG funds to develop common elements in our respective performance contracts as regards integrated treatment (screening, assessment, integrated services, consultative and collaborative relations between DA programs). We will coordinate an approach to assessing the fiscal solvency of our common provider network and understanding their budget needs. As part of this, we will develop a common approach to rate setting for integrated treatment services. ADAP and DMH will explore how we could revise our respective reimbursement practices to insure that each of our funding streams can support the provision of integrated treatment to eligible clients with co-occurring disorders. Finally, we will jointly plan for resource development, based on the findings of our systems evaluations.

Project Approach

Comprehensive, Continuous Integrated System of Care (CCISC)

The project approach is based on the systems change framework called the Comprehensive, Continuous, Integrated System of Care model (CCISC) (25) developed by Ken Minkoff, M.D. The CCISC uses quality improvement and planned, incremental steps at the system, program, and clinical practice and clinician competency levels to achieve integrated systems of care. The CCISC was specifically designed to improve service delivery for individuals with co-occurring mental and alcohol/substance use disorders. CCISC assumes people with co-occurring disorders are already present in our client population, but because services have not been planned to deal with co-morbidity, implementing integrated services appears to be an extra initiative rather than fundamental in the services offered. The CCISC approach addresses this by 1) building the concept of integrated treatment into the job functions of each clinician, encompassing the capacity for screening, assessment (including assessment of stages of treatment), and delivery of stage-specific individual and group treatment, 2) designing specific practice guidelines to support this, 3) building those practice guidelines and procedures into expected program standards, and 4) creating system-level policies to support those standards. It is important to note that the CCISC does not represent a new treatment technology for individuals with co-occurring disorders, but, rather, describes a method for applying existing mental health and substance abuse technologies in an integrated, collaborative fashion. The CCISC model has been identified by SAMHSA as a clinical-consensus best practice for systems implementation for treatment of individuals with co-occurring disorders (25, 26, 27) and has been used in over eight states to implement different models of evidence-based integrated treatment.

The CCISC framework uses three evaluative tools designed to assess the capability of a system to provide co-occurring services at the clinician, program, and system level. The Vermont Integrated Services project will use the COFIT system assessment tool and the COMPASS program assessment tool (see Appendix 3). The CCISC approach also uses "Charter" documents. These documents reflect a consensus vision for the service system, lay out incremental expectations for change, and are updated annually. Charter documents typically begin with expectations for screening and evolve to include treatment and service network development. In addition, CCISC calls for the development of local program Action Plans. These Action Plans parallel the system Charter and specify next steps for change and milestones for local programs.

State Activities

The project activities will be organized at the state and local levels. The State level will feature an internal management team to re-deploy resources and make joint decisions about how to support the provision of integrated services. This team will be staffed by the Deputy Commissioners of DMH and ADAP and include other key managers responsible for clinical, fiscal, information systems, training and quality improvement. The internal management team will be responsible for addressing the systemic barriers that prevent or inhibit the provision of integrated mental health and substance abuse services. Specifically, the team will 1) review the current fiscal health of the provider network, 2) assess the capability to provide integrated treatment and set incremental goals each year to improve the system, 3) develop joint approaches to contracting, 4) inventory our respective data systems and develop new reporting mechanisms to fulfill the co-occurring performance measures, and 5) establish uniform clinical protocols for screening and assessment. The internal management team will use COFIT (see Appendix 3), to review the capabilities of the current treatment system and identify gaps in services that need to be addressed. Based on this inventory, the state team will undertake resource development targeted to address gaps in the system. The resource development will likely include expanding the use of the Medicaid program for co-occurring disorders treatment, re-deploying existing resources more effectively, and advocating for the appropriation of new funds. As the substance abuse treatment system in Vermont is under-funded, developing better capacity to meet the treatment needs of people with co-occurring disorders will likely require new resources to prevent this initiative from eroding the basic funds for treatment of non-co-occurring substance use and mental disorders.

The team will be specifically tasked to make decisions about changes to our respective treatment networks. The Secretary of the Agency of Human Services has specifically empowered its component Departments to reduce categorical and organizational barriers to integrated services of all types, and the Vermont Department of Health plans to use this project to pioneer the restructuring process envisioned by the Governor and Legislature.

A stakeholder advisory group, called the State Policy and Operations Team, will be convened. The group will be led by the commissioner of Health with designated staff from the Governor's office and the Divisions of ADAP and DMH. The State Policy and Operations Team will also include commissioner-level representatives from the Department of Corrections, and Vermont's Medicaid office (OVHA). In addition, the State Policy and Operations Team will include representatives from the state consumer and family member organizations, service provider representatives, VDH's Office of Minority Health, and other advocates (see Appendix 1: Letters

of support). The project director, the key operations manager from ADAP, and the staff team hired especially for the Vermont Integrated Services project will staff the state team.

The State Policy and Operations Team (SPOT) will be responsible for creating and promulgating a vision of integrated services for the behavioral health treatment system in the form of a Charter Document. In addition to the overall vision, the Charter will set specific goals and expectations for screening and assessment, training for service providers, and integrated program operations. The SPOT will advise DMH and ADAP on changing administrative practices that inhibit the provision of integrated treatment. Each month the SPOT will review data reports on the results of our developing screening and assessment procedures, outcomes reporting, and progress of project implementation. The SPOT will also help identify the priorities for developing new service resources.

The internal management team in consultation with the SPOT will oversee the systems change process that will be characterized by quality improvement and incremental expectations for change. Each year we will set new priorities for state-level work and parallel expectations for changes in local treatment systems. The SPOT will meet ten times per year and will chart the progress of the systems change project via the COFIT assessment tool, the achievement of major milestones as detailed in the action plan (see below), and regular reports from the program evaluator on the co-occurring performance measures (see Section C). This approach will provide multiple sources of regular feedback on progress towards identified goals and allow for modifications and improvements to the project plan as the initiative progresses. The SPOT and Internal Management Team will also create subcommittees for specific work tasks such as improving the levels of cultural sensitivity and competency in service provision.

Local Activities

The local systems development work will take place in local behavioral health treatment programs and will be organized through the creation of two Regional Leader/Trainer cohorts. Each cohort will have 30-40 individuals who are clinical and administrative program leaders of the local services system, appointed by their respective treatment systems to lead a systems change and staff training process at their home programs. Each Regional Leader/Trainer cohort will meet six times a year. They will learn about clinical and service principles of integrated treatment and will in turn provide clinical consultation and training on integrated services to the staff of their home agencies. This will include training for line staff that focuses on expanding competencies in specific researched approaches to screening, assessment and the areas of consultation, coordination and integration. This training of trainers approach will allow the clinical staff the opportunity to own the adoption of new approaches and the management the necessary skills to perpetuate the practices even though there is significant staff turnover. In addition, the Leader/Trainers will organize the development of local action plans at each of their programs to carry out the goals identified in the State Charter. This will include the development of screening and assessment protocols and processes for consultation, coordination and integration. There will be active consideration by all agencies of the establishment of a universal intake/treatment record process forms that better facilitate the processes involved in the coordination and integration outpatient client care.

In order to facilitate communication between each of the local level Leader/Trainer groups and the state, we will form a steering committee of representatives from each cohort. The steering committee will be represented on the SPOT and will also meet regularly with project management and staff. In this role, members of the Leader/Trainer groups will provide critical

information about the systemic barriers to integrated services for the State Policy and Operations Team and Internal Management Team. The Leader/Trainers will provide practical feedback and propose alternative approaches to designing payment mechanisms and clinical and administrative procedures that support enhanced, integrated services. Planning grants will be provided to participating organizations to help defray the cost of the local clinical and administrative leadership dedicated to this project. The allocation of planning grant resources will be contingent on full participation in the Regional Leader/Trainer Cohorts, the development of local Action Plans, and the achievement of key milestones named in the Action Plans.

The following Work plan details the specific steps and timeframes of this project. Activities to achieve project goals are categorized under two track: infrastructure development training activities:

Schematic of Specific Project Goals and Activities

GOALS and OBJECTIVES:

1. Standardized Screening and Assessment:

Goal: All clients serviced in Adult MH Outpatient programs, substance abuse treatment outpatient programs, and FQHCs will be screened and if indicated, assessed for both mental and substance use disorders.

Objectives: a) Establish universal protocols for screening and assessment, b) Establish evidence-based screening and assessment through training and increased expectation at state level

2. Financial Planning and Information Sharing

Goal: ADAP and DMH will develop the infrastructure and resources to manage, monitor and support integrated services to priority populations.

Objectives: a) Develop common reporting and analytical structures, including dual information systems and shared staff, on provision, management and evaluation of integrated treatment, b) Develop common approach to reporting co-occurring PPG measures, c) Develop common elements/expectations in performance contracts regarding identification and treatment, d) Assess fiscal policy, contracting and resource issues needed to support integrated treatment providers, e) Develop and implement fiscal changes to address needs, including: common elements in performance contracts, common rate setting for integrated services, using existing and blended funding streams for integrated treatment, and resource development

YEAR I TARGETS:

1. Recruit Project Staff
2. Establish State (Management Team, SPOT, Trainers Steering Committee) and local (DA Trainer/Leader Cohorts) working structures
3. Develop and implement state-level (Charter) and program-level (action plans) plans for year one
4. Develop initial structures for data collection and evaluation

Infrastructure Development Activities	Training Activities
1. `Convene internal management decision-making group. Approve work plan for year 1; appoint sub-committees (IS, clinical, contract). 2. Convene SPOT 3. Review current financial information for shared service providers; assess fiscal status of MH and SA programs. 4. Inventory current data flow to ADAP and DMH; identify new data elements needed to report performance measures; report baselines for each measure; begin to design integrated data sets for co-occurring performance measures.	1. Appoint 80 representatives from DAs, FQHCs, consumer, family, and advocacy groups as Leaders/Trainers for their respective programs. 2. Organize Leader/Trainers in two groups of forty; establish communication mechanisms (list-serve) 3. Establish steering committee of trainer/leaders. 4. Action plans & milestone reports from participating service providers

5. Review current performance contracts with DAs; identify common expectations for integrated treatment to include in each Division's FY 06 contracts. 6. Using the CO-FIT, DMH and ADAP assess the current integrated treatment capability of the provider network; identify specific administrative barriers that need to be addressed at state level 7. Develop consensus about an authorized list of valid screening tools and assessment processes appropriate for each participating program. 8. Include screening and assessment requirements in the SFY 06 performance contracts with DAs. 9. Design program review process including random chart audits to verify that screening has taken place and further assessment, if warranted has occurred. (% of treatment programs that screen and assess for co-occurring disorders)	5. Implement first year training curriculum: • orientation to Vermont Integrated Services Project , CCISC, expectations for program development (assessment of dual diagnosis capability, intake and screening) • principles of integrated treatment and the four quadrant planning framework • evidence based integrated practices for quadrants Two and Three • role and function of screening versus assessment and training in use of selected screening tools.
Progress Measures	**Progress Measures**
1. Baseline reports of co-occurring performance measures 2. Baseline systems assessment; established targets for change 3. Joint program reviews completed-baseline established 4. Screening requirements included in SFY 06 performance contracts with DAs.	1. Achievement of action plan milestones 2. Establishment of CCISC Trainer/Leader Groups

YEAR II TARGETS: 1. Improved rates of screening and assessment 2. Regular reports on co-occurring performance measures 3. Broad stakeholder participation in and ownership of process 4. Progressive system and local service milestones set	
Infrastructure Development Activities	**Training Activities**
1. Continue internal management decision-making group, SPOT, and Trainer Steering Committee meetings. 2. Complete year II program reviews and chart audits to report on progress towards year 1 goals and set year 2 targets for rates of screening and assessment. Document in the form of local Action Plan and Project Milestone Evaluation. 3. Continue development of integrated data sets for co-occurring performance measures. Begin collecting new data elements. 4. Report year 2 co-occurring performance measures 5. Review current performance contracts with DAs; identify common expectations for integrated treatment that can be included in each Division's FY 07 contracts. 6. Review, in detail, reimbursement practices for an adult with co-occurring disorders served in a substance abuse program and one served in a mental health program. 8. Administer the CO-FIT, review progress made in year 1, set new goals for year 2. 9. Begin development of formal linkage protocols between FQHCs and area mh/sa outpatient service providers	1. Convene the Leader/Trainer Cohort 6 times, implement year 2 training curriculum • Treatment planning; matching to stage of change • Case consultation • Gender and culturally responsive services • Using contingencies to promote learning • Clinical supervision 2. Provide program-specific technical assistance using Zialogic and Dartmouth 3. Action plans and milestone reports from participating service providers
Progress Measures	**Progress Measures**

1. Year II reports of co-occurring performance measures; improved rates of screening 2. Year II systems assessment; new established targets for change; year I targets achieved 3. Joint program reviews completed 4. Assessment requirements included in SFY 07 performance contracts with DAs	1. Achievement of action plan milestones 2. Continued CCISC Trainer/Leader Groups 3. Increased infrastructure development at the local level (assessment)

YEAR III TARGETS:

1. Increased Rates of screening and assessment
2. ADAP/DMH have join data analysis and reporting capability
3. Unified approach to rate setting and contracting for integrated treatment
4. Regular reports on co-occurring performance measures

Infrastructure Development Activities	Training Activities
1. Continue internal management decision-making group, SPOT and Steering Committee 2. Complete year three program reviews and chart audits to report on progress towards year 2 goals and set year 3 targets for rates of screening and assessment. Document in the form of local Action Plan and Project Milestone Evaluation. 3. Adapt ongoing quality management and site visit activities to include screening, assessment milestones and indicators of integrated treatment services. 4. Finish development of integrated data sets for co-occurring performance measures. 5. Report year 3 co-occurring performance measures 6. Review current performance contracts with DAs; identify common expectations for integrated treatment that can be included in each Division's FY 08 contracts. 7. Revise reimbursement practices for substance abuse programs and mental health programs to insure that integrated treatment is supported 8. Identify needed resources for integrated treatment; prepare budget submission for FY 08. 9. Administer the CO-FIT, review progress made in year 2, set new goals for year 3. 10. Implement linkage protocol between FQHCs and area mh/sa outpatient service providers	1. Convene the Leader/Trainer Cohort 6 times, implement year 3 training curriculum • Group work, motivational interviewing, relapse prevention and recovery services • Prevention approaches • Treating trauma • Clinical supervision 2. Provide program-specific technical assistance using Zialogic and Dartmouth
Progress Measures	**Progress Measures**
1. Year III reports on co-occurring performance measures; increased rates of screening & assessment and improved client functioning (employment, incarceration, economic independence) 2. Year III systems assessment (COFIT); year II targets achieved; new targets set 3. Joint program reviews completed, integrated with ongoing QM/QI efforts 4. Budget submission for FY 08 documents plan to address needed resources	1. Achievement of action plan milestones 2. Continued meeting of trainer groups 3. Increased infrastructure development art local level (consultation, treatment matching)

YEAR IV & V TARGETS

1. Maintenance of Evaluation efforts
2. Integration of co-occurring performance measures in going data and reporting systems
3. Anchoring infrastructure changes in formal promulgation of policies & procedures for integrated treatment
4. Continued Reporting of performance measures

Leaders/Trainers form clinical consultation team

Infrastructure Development Activities	Training Activities
1. Polices and procedures governing screening, assessment, consultation, coordination are developed 2. Policies and procedures for uniform data reporting and 3. reimbursement are developed 4. Ongoing QM/QI activities modified to include integrated treatment performance measures	1. Leader/Trainers provide ongoing, in-house training at local agencies 2. Leader/Trainer Steering Committee re- 3. orients to provide clinical consultation to service providers
Progress Measures	**Progress Measures**
1. Year IV and V reports on co-occurring performance measures show uniform screening, assessment and improved client functioning with integrated treatment	1. Active clinical consultation within and across programs

Other Areas of Critical Infrastructure Development

Complimentary Licensing and Credentialing

The ADAP has developed an extensive training and credentialing program for drug and alcohol treatment counselors. Three years ago ADAP delegated responsibility for the management of the credential to the Vermont Secretary of State's office, where management of the guild-based licensure for mental health counselors, social workers, psychologists, and so forth is housed. DMH has no credentialing requirements for the bulk of its contracted workforce other than that they practice under the general supervision of a DA psychiatrist, and those required by Medicaid primarily for individual and group psychotherapy in the non-SPMI programs. Consistent with national credentialing bodies, Vermont does not require its licensed drug /alcohol counselors, social workers, mental health counselors, or psychologists to demonstrate skills in providing integrated treatment for individuals with co-occurring mental and substance use disorders.

Vermont is working towards an initial step of requesting that the guilds revise their Continuing Education requirements to include training in the complimentary discipline. However, until we have better defined the scope of practice for solo, licensed practitioners and addressed funding stream and reimbursement issues, Vermont proposes not to focus on this capacity building goal in this CO-SIG application.

Service Coordination and Network Building

The treatment system is underdeveloped in four key aspects. First, the alcohol and substance abuse treatment and prevention system lacks sufficient funding to provide a comprehensive system of prevention, intervention, treatment and recovery support services. For example, there is little capacity to treat individuals in the third quadrant (substance dependence) outside of episodic intensive residential treatment and as a result it is difficult for the service system to retain people in treatment. As retention in treatment is a key predictor of good outcome for clients, this is a serious efficacy issue for our system. This is why Vermont has chosen to focus this COSIG on outpatient services.

Second, there are few formal protocols to guide a referral process from one program to another for more in-depth assessment, case consultation, or integrated treatment planning for co-occurring substance and mental disorders. While both mental health and substance abuse adult outpatient treatment programs routinely encounter clients with co-occurring disorders, the billing systems, program requirements, and even clinical documentation for the medical record are all designed as if only one disorder is being treated. Third, there is no expectation for services

coordination, consultation, and integration. When integration happens, it does so *in spite of* barriers requiring, frankly, extraordinary creativity and extra effort on the part of local program leaders.

Finally, existing mental health and substance abuse services have done little to make treatment welcoming and accessible to ethnic minorities and special populations (e.g. women, the elderly, the deaf and hard of hearing) in Vermont that are in need of prevention and treatment services. Due to the relatively high number of non-Hispanic whites in Vermont (96.2% of population), delivery of services tends to be structured with a "one-size-fits-all" approach that does not take into account the diverse ways in which ethnic minorities and special populations understand, seek, and use assistance from the service system. For example, the elderly are much more likely to seek assistance for mental health or substance abuse issues through their primary care physician, but primary care services are not currently structured to refer for treatment of co-occurring disorders. Women with children are much less likely to ask for and engage in treatment if childcare is not available or the danger of losing custody of their children is present, yet existing services are not structured to address these barriers to access. Finally, little attention has been devoted to developing culturally competent services that are responsive to the unique engagement and treatment needs of Vermont's ethnic minorities.

While not one of the infrastructure development goals specifically selected for this project, ADAP and DMH believe that our overall project approach will have several positive impacts on *service coordination* and *network building*. First, the internal management team and the SPOT will make recommendations for the development of new resources and programming based on our assessments of services gaps using the COFIT. In addition, the local Leader/Trainer Cohorts are expected to help develop integrated treatment capacity at their respective programs. They will, for instance, receive training on clinical case consultation. The involvement of the FQHCs in this project will require that referral arrangements between area primary health providers and DA behavioral health outpatient programs be developed. Working with drug courts, corrections clients, and families in crisis will further define referral arrangements. The developing screening and assessment process will jump start the coordination of services between programs because inevitably, not all clients will enter the system through the most appropriate treatment door. Finally, the local DA action plans, required each year in the CCISC framework, will likely include mechanisms for appropriate referrals and consultation between agency programs.

Progress Towards Developing and Supporting Integrated Treatment

The 1997 Vermont legislative session passed the nation's first Mental Health Parity bill. This landmark legislation *includes* alcohol and substance abuse disorders and requires all public and commercial third-party payers operating in Vermont to provide behavioral health care coverage on par with physical health care benefits, with no arbitrary limits or exclusions. Initial pilot data from Vermont and the body of empirical evidence from around the nation suggests that the adoption of an integrated treatment model as a statewide exemplary practice would be fully supported by commercial third-party carriers.

Vermont has made some progress towards developing capacity for providing integrated services to persons with co-occurring disorders. DDMHS, ADAP and the Department of Corrections blend funding to support two pilot programs for individuals with co-occurring psychiatric and substance disorders who are in trouble with the law—individuals who often fall into Quadrant IV (severe mental disorder/severe substance disorder) and are served in Setting IV (jails, forensic units). While successfully achieving expected consumer outcomes (reduced

hospitalization, incarceration, and increased community tenure, treatment and sobriety), the pilots have had limited impact on other programs locally or in other parts of the state.

ADAP and DDMHS have already developed a Memorandum of Agreement on sharing information and MIS systems. Staffs in both agencies collaborate on solving provider data issues, data collection and analyses.

Finally, the decision to move the Division of Mental Health to the Department of Health is part of the reorganization of the Vermont Agency of Human Services. The vision for reorganization is grounded in the experience of Vermont's citizens at local service sites. The concept is to organize the flow of funding and human resources to support families and individuals in a coordinated, holistic manner. This requires that traditional categorical lines for client eligibility, financing, and services responsibility be permeable in order to better meet people's needs and to make more effective use of our limited resources.

Involvement of the SMHA, SSA and other Relevant Agencies

The state Divisions of Mental Health and Alcohol and Drug Abuse Programs will lead this Vermont Integrated Services Project. The project will focus on the adult behavioral health outpatient treatment system administered by ADAP and DMH and the interfaces between that system and other related agencies. Participation of key treatment services at the state level will be organized via the State Policy and Operations Team. As described earlier, this team will include the commissioners and key operations staff for DMH, ADAP, Medicaid (OVHA) and Corrections. The Commissioner of the Department of Health will join this team, providing an overarching authority to the work team that supersedes the boundaries of the ADAP and DMH. The Governor has assigned a member of his staff to the SPOT team. The membership of the State Policy and Operations Team will also include other stakeholders (see below: *Stakeholder participation*). Two program staff hired for this project, will staff the state team. This will help insure that each system, mental health and substance abuse, receives equal attention in this project.

The internal management team will be charged with redeveloping financial, clinical, and operational functions of the behavioral health service system. Making such changes requires the development of new and different policies and regulations. Working from the concepts of "anchoring" and "back filling" central to the CCISC framework, operational changes will be systematically embedded in the administrative processes that run the systems. Changes in contracting, performance expectations and policies will be institutionalized in our bureaucracy, thus insuring sustained and enduring changes.

Linking the State and Local Activities of the Project

As a small state, Vermont has a compact governance and management structure. The State SMHA and SSA contract directly with local service providers. This project will take advantage of that direct relationship and will build several project-specific linkages between the state and local level activities and participants. First, the state-level project staff will have regular contact with the Regional Leader/Trainer groups. Local service providers will choose the members of the Regional Leader/Trainer groups. The Regional Trainer/Leader groups will meet six times a year for training and to provide feedback about barriers to integrated services and proposed steps to address these barriers. The two regional groups will elect representatives to form a single steering committee that will meet regularly with the internal management team and will be represented on the SPOT. The project directors from the SSA and the SMHA will attend these

meetings. In addition, meeting summaries of the State Policy and Operations Team and its subcommittees will be distributed to the regional Leader/Trainer groups. In addition, the project staff will create a computer list serve for the Regional Leader/Trainers, the project consultants and the State Team. The list serve will facilitate communication by providing an accessible forum for questions and responses, identification of issues, ideas to address these, and trainings of interest. In summary, the Regional Leader/Trainer groups will be the project's bridge between state and local activities.

The annual development of the State Charter Document will also link the state and local levels of the project. The State Policy and Operations Team will draft the State Charter document and circulate it to the Regional Leader/Trainers, local programs, and advocacy stakeholders for input and revision. Once the Charter is finalized for the year, it will be widely promulgated. The Charter will serve as the organizing document for the systems change process by articulating the vision for integrated services and outlining the specific expectations for change for each year.

Each participating local behavioral health care provider will develop a program-specific action plan for incremental change based on the overall requirements in the State Charter. Project staff will review these plans, suggesting revisions where appropriate. Local planning grants will be awarded each year to participating providers based on three criteria: 1) active participation in the Regional Leader/Trainer cohorts, 2) the development of an approved action plan, and 3) the achievement of major annual milestones detailed in the action plan. The action plans therefore serve multiple functions; they organize the work at the local provider-level and link state expectations to local activities. Furthermore, accomplishing the milestones in local action plans embeds change in local program operations, assuring sustainability.

Stakeholder Participation

A diverse group of stakeholders participated in the preparation of this proposal. The commissioners of DDMHS and the Health Department invited thirty individuals to attend a half-day meeting to inform the AHS leadership of what "state-level policies and practices need revision to support the development and implementation of co-occurring treatment throughout the state" (28). Participants included the mental health consumer and family advocates for adults and children, advocates from the recovery community, and the advocate organization for the substance abuse prevention programs in schools. Local alcohol and substance treatment providers and local mental health treatment providers participated, and, in addition, the statewide provider advocacy organizations for both substance abuse and mental health attended the meeting. The commissioner of Vermont's child welfare agency (SRS) sent a high-level designee, and the commissioner and clinical director for the Department of Corrections attended. The Juvenile Justice Commission director attended the meeting to speak on issues of youth and the criminal justice system.

Each stakeholder spoke about changes needed at the state level to support local implementation, and these comments formed the basis of this proposal. Specifically, stakeholders identified lack of a unified vision for services, the impossibility of meeting the needs of whole people with specific issue based programs, fragmented and confusing services that make it extremely difficult to access care in a timely fashion, major gaps in services for youth in transition, poor screening and treatment protocols for older adults, lack of ongoing care after intensive residential treatment for substance dependence, and lack of coordination and collaboration between mental health and substance abuse providers. In addition, participants

described administrative barriers to integrated care including billing systems that only allow a single diagnosis, burdensome and disparate clinical documentation requirements, and significant work force retention issues due to low pay for behavioral health providers and credentialing requirements for alcohol and substance abuse providers specifically.

Based on this input, the Vermont Integrated Services Project is designed to include several important stakeholders in addition to the traditional behavioral health providers and advocates. Two large Federally Qualified Health Care Centers (FQHCs) will participate in the project; both will send representatives to the Local Leader/Trainer groups and participate on the State Policy and Operations Team (see Appendix 1: Letters of Support). This will assist the project to pilot and refine linkages between specialty behavioral health services and primary care. The Recovery and consumer advocate communities will be invited to send representatives to the Leader/ Trainer groups and develop action plans to help assure that the advocacy and support services that they provide are co-occurring-capable. Representatives from their respective statewide leadership organizations will serve on the State Policy and Operations Team. The participating behavioral health service agencies at the local level are all private-not-for-profit organizations. Vermont's Medicaid Authority, the department of PATH, will participate in the State Policy and Operations Team and is committed to working with the SMHA and SSA to change the state's Medicaid plan provisions and operations to support integration of services for people with co-occurring disorders. These changes, in turn, will impact the over 700 private, independent clinicians who are registered Medicaid providers. In recent years, VDH has also been working with local business communities and primary care stakeholders regarding the problems of substance abuse, and VDH will work with already established alliances to involve these stakeholders in the project. Finally, VDH's Office of Minority Health will work to ensure the voices of various minority groups are heard. While Vermont is predominately non-hispanic white (96.2%), small ethnic communities exist in various parts of the state, including resettled refugees from Asian, Eastern Europe and Africa in the northeast of Vermont, American Indians and French-speaking Vermonters from the communities bordering Canada, and a small deaf community in southeaster Vermont. These communities will work with the project to ensure integrated services are modified locally to meet diverse needs. Finally, VDH will use its relationship with the spiritually-based peer-run recovery communities (e.g. Upper Valley Substance Abuse Foundation – see Appendix 1) to solicit the involvement of faith-based organizations.

Stakeholder Feedback

The project staff, including the research assistant, will organize a series of focus groups designed to provide policy makers and local program leaders with concrete information about how behavioral health services can work together more effectively on behalf of clients/consumers. These focus groups will target input from groups and individuals who may not be directly represented on the State Policy and Operations Team or Local Leader/Trainer groups. Specifically, focus groups will be developed with the following groups: local education administrators, the Refugee Resettlement Project communities, law enforcement, American Indian communities, parents of youth in detention and/or custody, and women's groups. The information developed from these groups will be used to inform the agenda for the work of the State Policy and Operations Team (such as the formation of specific subcommittees charged with system development tasks including cultural competence and diversity) and to develop new

training topics for the Leader/Trainer meeting sessions. In this way, the input will be folded into the overall work plan of the project.

Project Practicality and Feasibility

Large systems change projects require dedicated staff and a strategic plan or approach. The CCISC framework, combined with very specific project goals, will help organize the process. The State and local work is organized into four key forums, the state-level internal management team, the State Policy and Operations Team, the two Local Leader/Trainer cohorts, and the Leader/Trainer steering committee. The State Charter, the organizing document, parallels the development of local action plans. The State Policy and Operations Team and internal management team address systemic barriers, while the local Leader/Trainers organize the work of the local action plans addressing individual programmatic barriers. Regular use of systems assessment instruments, the COFIT and the COMPASS (see Appendix 3), throughout the project will both help to identify the particular targets in need of change and will help measure state and local progress toward accomplishing goals. The Charter and the local action plans are both designed to focus on incremental changes in a phased project. We believe strongly that it is better to set achievable goals and work toward these than to set out a vision that is beyond the capabilities of the system to implement. The provision of local planning grants to support the development and implementation of action plans and participation in the Leader/Trainer cohorts will help to defray the costs of securing high-level participation in the project. Behavioral health providers unanimously report that they need additional resources in order to free up staff time from billable work to participate in these kinds of projects. Finally, making payments contingent upon participation and actual implementation of programmatic reforms aligns financial incentives appropriately.

As previously mentioned, DMH is in the midst of implementing a three year Evidence Based Practice (EBP) Training and Evaluation Grant to develop integrated treatment in the 10 DA programs for adults with SPMI. We are using the Dartmouth Psychiatric Research Center Integrated Dual Disorders Treatment (IDDT) Implementation Resource Kit in conjunction with the CCISC system change framework. The project employs a state-level operations team, a state Charter document, a local leader/trainer cohort getting IDDT Resource Kit training, and local action plans, and offers planning grants to local service providers. This project is proving much more successful than any of our prior training initiatives on co-occurring disorders. The combination of outstanding training content of the Resource Kit with the CCISC framework is working very well. In fact, it has been extremely difficult to restrict the project to the SPMI target population as specified in the SAMSHA Grant program because of wide interest from other behavioral health programs (children and youth, substance abuse, outpatient mental health services, and inpatient) to participate in the project. It is also clear that one- and two-year projects are not sufficiently long to develop the overarching system and programmatic changes needed to develop a behavioral health system's co-occurring capabilities. Our experience in implementing the EBP Training and Evaluation grant has allowed us to develop a feasible project proposal for COSIG funds and has helped us to scale this proposal appropriately.

In the last four years ADAP has focused on evidence--based, manualized treatment for *adolescents* as well as use of standardized screening and assessment tools that incorporate attention to co-occurring mental and substance disorders among adolescents. An extensive training program has been started using the GAIN and MAYSI assessment and treatment planning protocols. Five DAs are serving as pilot sites for implementing manual-based treatment

for adolescents and using the GAIN assessment and follow-up. ADAP proposes to use the Vermont Integrated Services Project to expand and create incentives for the use of the GAIN for all adult outpatient substance abuse treatment providers on the grounds that the use of standardized, comprehensive assessment tools will help referrals and coordination of care between substance abuse and mental health providers to become routine practice. The DMH is reluctant to impose a single screening or assessment tool for all adult outpatient programs (out patient, SPMI, emergency, elder care, transition aged youth) yet fully recognizes that coordination of care across programs requires that we speak a common language. Both ADAP and DMH are committed to using this project to work through these issues and to develop uniform reporting capabilities for co-occurring disorders.

The Vermont Integrated Service Project also builds on the work of four existing project collaborations that demonstrate Vermont's skills and experience in achieving systems coordination and integration. These are the Co-Occurring Disorders Treatment Pilots, the Medical Home Project, the local and State Interagency Teams for Children, and the Homeless Health Care Project.

As described earlier, DMH and ADAP have been involved in a project with the Department of Corrections to fund and coordinate two Co-Occurring Disorders Treatment pilot programs for individuals with co-occurring psychiatric and substance disorders who are also in trouble with the law. The pilots integrate mental health, substance abuse, and probation and parole staff in a single intensive treatment team. These pilots have helped the DDMHS, ADAP, and the Department of Corrections gain experience in collaborative management of integrated services for adults with co-occurring disorders.

Funded by a grant from the Robert Wood Johnson Foundation, Vermont's Medicaid Agency is collaborating with DMH and local Designated Community Mental Health Agencies (DAs) to better address coordination between primary health care and mental health programs serving people with SPMI. The project involves testing a nurse case manager model to provide health care and to link SPMI clients more effectively with the primary care system. Through this project, Vermont is learning about how to effectively coordinate mental health and primary care services.

The State and Local Interagency Teams for children and youth are responsible for developing and funding interagency treatment plans on behalf of youth. The process is dedicated to "de-categorizing" the resources of our Education, Mental Health, Child Welfare, and Juvenile Justice programs on behalf of children to secure appropriate services and to prevent out-of-state residential placements. This work has helped us learn how to combine funding streams and to break down programmatic silos.

Finally, Vermont's Homeless Health Care project is an interagency collaboration located in our largest city, Burlington. The project combines primary health care, mental health and substance abuse treatment services, vocational rehabilitation, drop-in centers, and outreach teams to serve people who are homeless. This multi-agency collaboration has successfully navigated systemic barriers to coordinated services provision for a very difficult-to-engage population, people who are chronically homeless.

Vermont will build on our experience gained from these examples of multi-agency collaboration in this proposed Integrated Services Project.

A.2. Services Pilot

Vermont does not plan to conduct a services pilot.

SECTION B - ORGANIZATIONAL AND STAFFING PLANS

Lead Agency and Organizational Capability

The Vermont Department of Health (VDH) will be the lead agency for the Vermont Integrated Services Project. VDH has a demonstrated track record with large grants and system development initiatives. VDH is a large, Department-level organization with the requisite fiscal, programmatic, and information systems capabilities required for a project of this scope. Fiscal administrative oversight is provided by the Business Office, part of the Administration Division, in conjunction with individual program managers. The Business Office provides fiscal oversight to more than 800 grants totaling $38,211,825 for FY04. Programs are subject to controls on the obligation and expenditure of funds, such as competitive bidding for purchases and approval processes for authorizing payments to vendors. Uniform reporting requirements for all sub recipients of Department funds will be implemented July 1, 2004. These requirements set standards for reporting, both programmatically and fiscally, based on grant dollar amount and other "risk factors" associated with the sub recipient. The Department requires that all work hours be positively reported by employees to specific programs, with timesheets reviewed by direct supervisors. VDH uses a cost allocation plan approved by the federal Department of Health and Human Services to allocate its overhead and leave time costs. One of the strengths that VDH brings to the project is its Office of Minority health which will help to assure the development of inclusive, culturally competent care and assist with eliminating the disparities between outcomes between the general and minority populations.

The DMH and the VDH Information and Computer Services Divisions and the Business offices have extensive analytic capabilities. The DMH Research and Statistics Unit has extensive experience working with other data bases maintained by Vermont state government including the Medicaid Claims Processing, Medicaid Pharmacy, Hospital Discharge Data Set, the wage and salary data base maintained by the Department of Employment and Training, and the Department of Corrections data. DMH regularly reports on cross-data systems analysis through the federally supported Performance Indicator Project.

Staffing Plan, Lines of Authority, and Qualifications of Key Personnel

The overall project director will be Beth Tanzman, M.S.W (20% time devoted to the grant). She will work under the direction of the Deputy Commissioners for ADAP and DMH. Ms. Tanzman is the Director of Adult Community Mental Health Services for DMH. She is responsible for overseeing the community-based SPMI programs, the outpatient mental health programs, the 24-hour mental health emergency service programs, and the DMH Acute Care system managing key aspects of Vermont's Medicaid inpatient benefit. Ms. Tanzman reports directly to the Mental Health Division Director who reports directly to the Deputy Commissioner of DMH who in turn, reports to the Commissioner of the Department of Health. She is the lead investigator for Vermont's current SAMSHA EBP Training and Evaluation Grant on Integrated Dual Disorders Treatment. In addition, she was the lead investigator for two Community Action Grants for co-occurring disorders (phase 1 and 2). Under her leadership, Vermont has participated in several initiatives related to the implementation of evidence-based practices including being a pilot site for the national evidence-based practices demonstration project for illness management and recovery and family psycho-education.

Linda Piasecki, Operations Director for ADAP (20% time), will assist Ms. Tanzman. Ms. Piasecki is responsible for the oversight of all ADAP services contracts, and general policy and operations for ADAP programs. Ms. Piasecki reports to the ADAP Deputy Commissioner, who in turn reports to the Commissioner of the Health Department. Ms. Piasecki will draw on the expertise of ADAP's Chief of Treatment, Peter Lee, MS, Psych. Mr. Lee worked with Drake et al in New Hampshire providing integrated treatment 20 years ago. Together Ms. Tanzman and Ms. Piasecki will organize the project activities and supervise the project staff. These two managers will ensure that the project is embedded operationally in the both the SMHA and the SSA.

The Vermont Integrated Services Project will six additional FTE staff who will report to the overall project director. We will hire two Integrated Treatment Program Specialists who have clinical leadership experience in the provision of integrated treatment. The program specialists will be responsible for the day-to-day staffing and planning of the State Policy and Operations Team and the Regional Leader/Trainer Cohorts. They will work closely with the participating project service providers on the development of local action plans and the maintenance of the computer list serve. Qualifications required for these positions will include a Master's degree in rehabilitation counseling, counseling, psychology, social work, or related human services area, knowledge about integrated dual disorder treatment, and experience with providing integrated mental health and substance abuse treatment. .

The Vermont Integrated Services Project will hire one FTE Data Base Administrator. This position will be responsible for integrating the existing data flow from the ADAP and DMH information systems into a single database for analysis and reporting. In addition, the database administrator will integrate any new data elements identified (screening, assessment, client outcomes) for the project into our existing data systems.

A Senior Research and Statistics Analyst will be hired for the project. This position will be responsible for producing analytical reports on DMH and ADAP data. Besides marking the progress of the system towards integrated treatment, these reports will create a feedback loop to service providers to improve the accuracy and comprehensiveness of our data. The position will also design reports that interface with other State databases (Medicaid claims, criminal justice, employment and training) to track the impact of the services developed under this initiative.

The Data Base Administrator and the Research and Statistic Analyst we be supervised by the Director of the DMH Research and Statistic Unit, John Pandiani. He will provide supervision of analysis of data and overall guidelines to the evaluation plan. Mr. Pandiani (20% time) has been Chief of Mental Health Research and Statistics in Vermont for 18 years. Before joining the state, Dr. Pandiani was Research Director at Washington County Mental Health Services, and Assistant Professor of Sociology at Middlebury College in Vermont. Dr. Pandiani is a founding partner in The Bristol Observatory, an evaluation and service system research organization that provides data analytical and consultation services to government agencies and research organizations.

The project will also recruit and hire one FTE program evaluator. The evaluator will be responsible for organizing the grant activities tracking system. The evaluator will work with the Program Specialists on designing and reporting on the stakeholder focus groups. General work will be under the supervision of the project director with analysis of data under the supervision of the DDMHS Research and Statistics Director

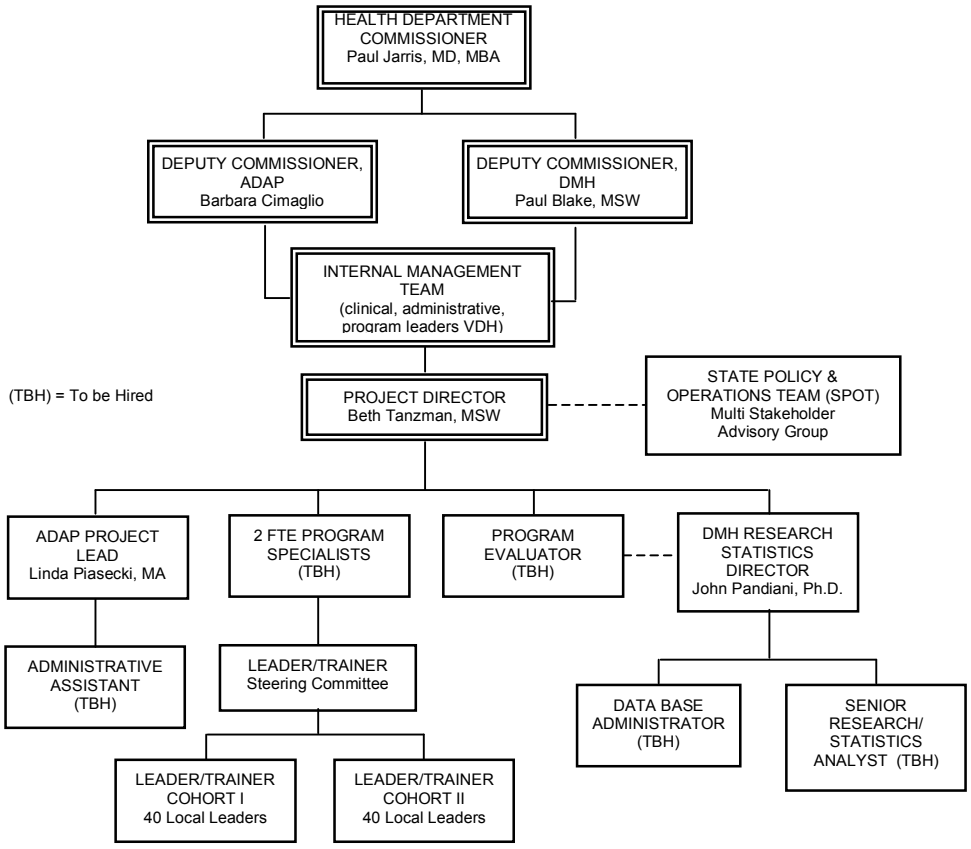
The Director of the Office of Minority Health, Muderhwa Jaques (20% time), will contribute a portion of his time to this project and help to provide links to the minority community at both

the state and local levels. The office is committed to inclusion and the delivery of services which are respectful and responsive to the minority being served.

One FTE administrative assistant will be hired to support the project activities. Their duties will include: work in preparing documents and mailings, assisting in the planning for meetings and training events and designing informational documents. Minimum qualifications for the position will include: an associate's degree in business technology, secretarial science or office management; or high school graduation or equivalent and three years of office clerical experience.

Finally, the project will contract with two consulting groups: the NH-Dartmouth Psychiatric Research Center (PRC) (40 days) and ZiaLogic (40 days), a consulting firm specializing in the development of co-occurring capable behavioral health systems. Both consulting groups are established national leaders in the area of implementing integrated treatment. Lead consulting staff will work directly with the internal management team and the State Policy and Operations Team throughout the project. In addition, the consulting staff will develop and deliver the training and systems change curriculum for the two local Leader/Trainer cohorts. The consultants will assist the project director with securing specialized training or consultation as needed to address the needs of specific clinical populations, developing culturally competent and appropriate services, and other administrative consultation as needed. Additional consultant will be used to provide specific training on topic areas (e.g. specific screening tools) as needed.

Organizational Chart



Project Facilities

Project activities will be organized from the offices of the Vermont Department of Health. These offices are fully accessible and meet the requirements of the Americans with Disabilities Act. Each staff member will have private office space with an ergonomically designed work station, a personal computer with internet connection, and a telephone line. Training activities and meetings may be in local hotels and other public meeting spaces. DMH and ADAP, consistent with Vermont State policy, will only sponsor events and meetings in facilities that meet the requirements of the Americans with Disabilities Act.

Compliance with Reporting Requirements and Participation in TA Meetings and Cross Site Evaluation Activities

The Vermont Integrated Services staff will fully meet SAMSHA reporting requirements in a timely fashion. We appreciate that these demonstrate accountability for federal funds and assist SAMSHA to provide useful information to other states and projects. The VDH commits, with enthusiasm, to cooperating with, coordinating with, and supporting the efforts of SAMHSA's Co-occurring Cross Training and Technical Assistance Center. The VDH agrees to participate in a cross-site evaluation and to send at least two staff to two evaluation meetings each year. We commit to collecting and reporting on the outcome indicators using the standards developed for the CO-SIG awardees. Finally, we commit to send senior project leaders to two technical assistance meetings each year of the project. The costs to attend the biennial evaluation and technical assistance meetings are included in the budget for this proposed project.

SECTION C – EVALATION/METHODOLOGY

The long-term goal of the Vermont Department of Health is to be able to successfully identify all individuals with co-occurring disorders, provide them with appropriate stage-related integrated services, and hence, improved outcomes. This project allows continued incremental growth of our data infrastructure and process evaluation methodology using the CCISC framework toward achieving this goal. We will build on our experience of other similar projects in Vermont and be guided in our evaluation by the consultants from Zialogic and the Dartmouth Psychiatric Research Institute, and a wide range of stakeholders within Vermont. We will continue to maintain links with, and learn from the experiences of, other sites currently involved in integrated treatment programs and the national EBP Demonstration Project in other states.

In this project, DMH and ADAP will work together to implement integrated treatment practices in their respective adult outpatient programs at provider sites with whom they both contract. While this project focuses on adult outpatient programs, the infrastructure gains in integrating DMH and ADAP screening and assessment, data reporting and financial planning structures from this project will facilitate expansion of integrated co-occurring disorder treatment practice into other behavioral programs in Vermont.

Specifically, this evaluation will:

1. Monitor the implementation process both at the state and local level: a) Tracking action plan milestone achievements, b) Documenting the Management Team, Training of Trainers and SPOT meetings, c) Identifying systemic barriers and ways in which these barriers may be overcome, d) Using focus groups and interviews to obtain the views of major stakeholders.
2. Measure the fidelity of integrated treatment practices at each site on an annual basis.
3. Collect, and improve on the capacity to report, co-occurring PPG measures.

4. Identify information system requirements to develop a unified reporting structure and common administrative dataset.
5. Evaluate client outcomes.

Both quantitative and qualitative methods will be used to support the evaluation. Quantitative data from existing administrative datasets and project-specific datasets will be analyzed using SPSS and Excel software. Qualitative data from sources such as focus groups, oversight groups, interviews of key personnel, and onsite observations, will be entered and coded for analysis in Atlas, a qualitative analysis software package currently being utilized by the National Evidence-Based Practices Demonstration Project.

The Evaluation Team

The evaluation relies on three key players: the evaluator, the data analyst, and the database administrator, each of whom will have a distinct role that informs the activities of the others. The evaluator's task is to chronicle the progress of implementation of the integrated co-occurring treatment practice statewide over the full five year period. This involves collecting grant specific information and providing ongoing feedback in a quality improvement framework to fellow evaluation team members, project program specialists, and the programs implementing co-occurring treatment practices, as well as representatives within VDH and national reporting organizations and other stakeholders. The data analyst will be responsible for using the administrative databases and the quantitative data collected by the evaluator to develop statistical reports. These reports will create a feedback loop to service providers to improve the comprehensiveness and accuracy of the statewide behavioral health dataset. The data analyst will also access other statewide databases (Medicaid claims, criminal justice, employment and training) to track the impact of the services developed for this project. The database administrator's task is to develop a common database using existing data requirements that satisfy DMH and ADAP needs as part of the alignment of the two organizations providing behavioral health care within the Department of Health. The database administrator will also build into the database the data fields deemed necessary by the evaluator, the data analyst and the management team to support identification of clients with co-occurring disorders and tracking of their treatment within adult outpatient programs.

The evaluator function will continue through the full five years of the grant, while the database set up is anticipated to be completed in three years. As part of sustaining capability, evaluator review activities would gradually be absorbed into the existing quality improvement review procedures at the state level. Activity in the fourth and fifth years will include standardizing the review process and familiarizing VDH quality management/improvement staff with the process. Data analyst activities will be absorbed by the VDH's research and statistics reporting functions by the end of the third year.

Process Evaluation

Process evaluation will involve a combination of quantitative and qualitative methodologies to collect information regarding systems change, adherence (fidelity) to integrated treatment principles, successful implementation strategies, and barriers to successful implementation of appropriate integrated treatment for individuals with co-occurring disorders. Strategies for information gathering will broadly follow guidelines recommended for the National EBP Demonstration Project. Together, these process measures will contribute to annual reports distributed to all major stakeholders that provide a comprehensive description of the degree to

which this project achieves its stated objectives and any systemic barriers hindering the implementation process.

System Change

The project approach is based on the CCISC systems change framework (25) developed by Ken Minkoff, M.D. As this framework is already being used in Vermont in an existing project for individuals with co-occurring disorders in Quadrant 4, the provider sites have already had some exposure to the methodology. Within this framework, there are four activities undertaken annually by both VDH and the provider network. Following the incremental change model, activities planned for each year will be based on accomplishments from the previous year. The four activities are as follows:

1. All participants will jointly develop a *Charter* in which VDH and providers commit to completing an agreed set of actions over the coming year. Provider expectations typically start with welcoming policy, training and screening activities and evolve over time to include treatment and service network development. VDH expectations typically address establishing management structures, involving stakeholder participation, providing recommendations on screening and assessment tools, and exploring common reporting, and contracting procedures.
2. VDH will complete the *COFIT* system assessment tool, and providers will complete the *COMPASS* program assessment tool (see Appendix 3). These instruments are self-report questionnaires rating current (system or program) capability to support and provide integrated co-occurring disorder treatment according to best practice principles. The scores from this exercise will be submitted for central analysis and comparison over time.
3. The state and local providers each draw up *Action Plans* for each year. These closely parallel the Charter specifying next steps for change, milestones and timelines.
4. At the end of each year the respective parties submit *Milestone Reports* outlining action plan steps that have been completed. A record will be kept of accomplishments contributing toward the overall goals of the project and any deviations from stated plans in order to be able to assess their impact on client access to care, outcomes and the overall evaluation process.

The documentation and analysis of these activities will be supplemented by qualitative information gathered during the year (see *Ongoing Process Evaluation* below)

Fidelity

Scores on the COMPASS and COFIT instruments administered at the start of the project and then annually thereafter will provide self-report information on the development of provider and state capabilities to support integrated treatment practices for clients with co-occurring disorders.

In addition to these self-report measures, we will be conducting annual on-site reviews to obtain external perspectives on fidelity to best practice principles. At present, there is no nationally recognized fidelity instrument other than the fidelity testing protocol developed by the Dartmouth PRC for individuals with serious and persistent mental illness. This instrument is being used in our ongoing project for individuals in Quadrant 4 and we already have a cohort of staff trained in its use. The information to generate fidelity scores is derived from a combination of record and administrative data review, standardized interviews and observations during a day long site visit by the evaluator and one other trained rater. For this project, we intend to follow a similar, possibly abbreviated, procedure. We will work closely with our consultants from Dartmouth PRC in developing a scoring protocol that is appropriate for tracking treatment for

individuals in Quadrants 2 and 3. Scores derived from these site visits will be submitted for analysis, and then reports together with scores for each of the identified components of best practice will be made available to each site within a month of their site visit.

Ongoing Process Evaluation

Another important aspect of the evaluator's responsibilities is to collect qualitative data to obtain an overall perspective of the progress of the project from as many points of view as possible. This will involve attending all key meetings relating to the project, documenting stakeholder and consumer focus groups and interviewing key personnel. Notes from these meetings and interviews will be transcribed and submitted to the ATLAS software to enable key issues to be categorized for analysis. As the aim is to obtain aggregate impressions of the overall implementation process statewide, reports will not contain personally identifying information.

Ongoing documentation is critical in identifying common or group specific issues, deviations to plans, new or improved approaches to achieve the overarching goals, and modifying support needs. Examples of key meeting activities that would be monitored in this way would be: the state level management team, Local Leader/Trainer Cohort 'Training of Trainers', and the activities of the State Policy and Operations Group.

Focus groups provide stakeholders and consumers a forum in which they can express their views about the project and the way it is evaluated. There will be two types of focus group held annually. Focus groups for stakeholders would be facilitated by the state project coordinators, and focus groups for consumers and/or the people close to them would be facilitated by representatives from advocacy groups.

Individual interviews with the program leaders at each site again provide an opportunity for feedback on the implementation process to the state. These interviews would focus in on the usefulness of the CCISC framework, the use of the training of trainers approach, local successes and barriers they encountered in their efforts to introduce the practice at their site, and how helpful (or not) VDH supports have been.

PPG Measures: Access to Care

A primary task of the evaluation is to develop the capacity to accurately report on the co-occurring PPG measures within the DMH and ADAP adult outpatient programs, namely, percentage of clients with co-occurring disorders, percentage of programs that screen, assess and provide integrated treatment following best practice for clients with co-occurring disorders, and outcomes for those clients. Vermont currently has the capacity to report the percentage of clients with co-occurring disorders served in the mental health and substance abuse programs at the sites for this project and to measure reduced impairment (see *PPG Measures: Client Outcome Measurement/Impact of Treatment* below), but does not systematically measure the degree to which programs screen, assess, and provide collaborative integrated treatment. Improving existing capacities and building missing capacities is a major focus of the data infrastructure component of this project.

The existing DMH database (the MSR) contains client data derived through the intake process and service data on people in both adult mental health and substance abuse programs for all its community mental health centers. While a substance abuse problem is indicated for 24 % of the clients in the mental health program, only 13 % actually have a DSM diagnosis for substance abuse. Similarly, a mental health problem is indicated for 62% of the clients in the substance abuse program, but only 23 % actually have a DSM diagnosis for mental illness.

Two initial methods of identifying individuals with co-occurring disorders will be used in this project for baseline reporting. One method is based on information in the current treatment databases (described above), thus reflecting the rate at which individuals with co-occurring disorders are identified by staff. The second method is based on integration with other databases that indicate substance abuse related problems (e.g. arrest databases and motor vehicle databases). During the first year of this project, both approaches will be applied to a number of recent years to provide baseline measures regarding the representation of individuals with co-occurring disorders. Results will reported to the national COSIG project within the first six months. During the balance of the project, the representation of individuals with co-occurring disorders will be monitored using an improved database with specific fields enabling identification of individuals with co-occurring disorders, their assessment data and the level of integrated treatment they receive. Our target for improvement in rates of identification of clients with co-occurring disorders through reported diagnoses is 10% improvement per year.

We will be also taking interest in a selected subset of clients with a greatly elevated risk for co-occurring disorders: people with a history of trauma. Following the definition of post-traumatic stress disorder provided by DSM-IV we will include a variety of forms of trauma including assault, injury, diagnosis of life threatening disorders, and others. Individuals with such histories will be identified in existing databases, their rate of participation in co-occurring services will be measured using the approach described above, and the resulting rate will be compared to the utilization rate for the general population. This approach is being developed by a SAMHSA funded NASMHPD demonstration project in which the Vermont DMH is participating (39).

PPG Measures: Client Outcome Measurement/Impact of Treatment

Outcome measurement is critical in evaluating whether co-occurring treatment practices contribute toward reduced impairment. Our outcome measures will involve analysis of the overlap of mental health and substance abuse treatment databases with other relevant databases. These outcome measures will include *criminal justice involvement, economic dependency,* and *employment.* We believe this broad range of treatment outcomes provides a strong basis for determining the impact of developing our service system's ability to effectively treat co-occurring disorders. We also believe this work will complement and contribute to the work of other participating states. During the course of this project, all of these outcome indicators will be applied to both service recipients identified as having co-occurring disorders and those who are not. Results for both groups will be compared to rates for the general population of the state. All outcome measures will be compared across local treatment programs, and among programs grouped by levels of participation in the project, by level of achievement of Action Plan milestones, and by degree of fidelity to the treatment model.

During the initial months of the project, the evaluation will focus on improving existing data and adding more detailed screening and assessment data to existing data systems. During subsequent months, attention to treatment outcomes will be added to the assessment to meet local and state reporting needs. These outcomes will have a strong emphasis on criminal justice involvement but will also include a concern for employment, economic dependency, and a history of trauma.

Administrative/operational databases play an important role in our measurement of access to care and treatment outcomes for a number of reasons. First, the data are available now. Program administrators need not wait while instruments are designed and data are collected. Second, the

analysis of administrative/operational databases is economical. The cost of new data collection is avoided. Third, these databases are comprehensive. They provide information about the population at large so that service recipients can be compared to other residents in terms of relevant measures (29).

Cross-database analysis will be facilitated by Probabilistic Population Estimation (PPE), a statistical tool that uses anonymous data to produce information on caseload size and overlap (30). PPE provides estimates (with known confidence intervals) of the number of people shared across databases by combining information about the distribution of dates of birth in data sets with information about this distribution in the general population. PPE determines how many people are represented in both databases, without revealing who the people are. For this reason, the personal privacy of individuals and the confidentiality of medical records are assured. PPE is not suitable for clinical applications that require the identification of individuals, but is a very powerful tool for services research and program evaluation where the identification of individuals is not required (31). In this project, PPE will be used to measure a variety of treatment outcomes for service recipients. Our approach to measuring access to care for special populations is described in *Evaluation and Program Planning* (40). Our approach to measuring treatment outcomes is described in *The Journal of Behavioral Health Services* (33 and 34).

Criminal Justice Involvement

Vermont has substantial experience measuring criminal justice involvement, including arrest, criminal charges, probation, parole, and incarceration. Our work in this area began with a focus on incarceration (33). More recent work found that there were substantial reductions in arrest rates, from 25% before to 17% after substance abuse treatment (34) for the 5,206 people served by substance abuse programs during FY2000. We have, however, found relatively little change for recipients of mental health services (35, 36). Rates of criminal justice involvement of mental health service recipients have been found to vary with types of services received (37, 38). Because of the difficulty of comparing criminal justice outcomes for programs with dissimilar caseloads, case-mix adjustment procedures that statistically control differences in caseloads across subject populations were developed and applied in Vermont (34). These procedures will be used, where appropriate, across outcome measures.

Economic Dependency

The impact of the treatment of co-occurring disorders on rates of economic dependency will be examined by measuring the degree of caseload overlap between the treatment programs and Vermont's "Reach Up" public welfare program. This is an area of investigation that has not been systematically developed in Vermont, although some preliminary analyses demonstrate the feasibility of this approach for measuring the impact of treatment programs. Former children's mental health service recipients were more than 50% more likely than other Vermont residents to be on the Reach Up caseload when they were 18-24 years of age. (42). Adults in both mental health and substance abuse programs have substantial numbers on the Reach Up caseload (over 25% of women and about 10% of men) (43).

Employment

Our final outcome measure is the rate of employment of service recipients after treatment compared to before treatment. Vermont has been monitoring rates of employment for recipients of community-based mental health services for adults with severe and persistent mental illness

for more than three years. This monitoring is based on analysis of caseload overlap between the state's mental health treatment database and the unemployment insurance database maintained by the state Department of Employment and Training. Results indicate that 30% of the 2,938 adults with serious mental illness were competitively employed during FY2002 (44). We have recently begun to examine the impact of employment services on employment rates (45). The proposed project examining a different population will help move this work forward in terms of both methodological sophistication and substantive content.

Inclusion of Stakeholders

In all of our evaluation activities, we will be inviting input and comment from a community of stakeholders. The State Policy and Operations Group (SPOT) and the Local Leader/Trainer Cohort Groups, and other interested parties will be core members of this community. Other members will include administrators from local programs and state level mental health, substance abuse, and other service systems, as well as direct consumers, family members, and advocates who represent behavioral health and various other minority and spiritual interests. The Director of the Office of Minority Health will assist with the inclusion of minority representation. Representation from the Governor's office and the state legislature will be solicited. This group will also involve representatives of all state agencies that provide data for the cross-agency data analysis that is a central part of this evaluation.

Process evaluation will take into consideration the views of all of these key players. Their contribution to, and development of feelings of ownership in, the implementation of appropriate integrated treatment for individuals with co-occurring disorders is key to success of the project.

Furthermore, this project proposes to involve all interested stakeholders in the design of quantitative analyses and the interpretation of findings using the model developed in its Mental Health Performance Indicator Projects (PIPs) over the past seven years. This model involves weekly distribution of quantitative evaluation findings (in narrative, graphic, and tabular format) to a broad range of stakeholders and interested parties. Each report includes a request for comments, interpretation, and suggestions for further analysis (127). These reports are followed by periodic face-to-face meetings with the stakeholder group to further the discussion of interpretation and analysis and to address issues of data quality.

This process, which has contributed to the emergence of a data-based culture among behavioral health providers, consumers, and advocates in Vermont, was the subject of a plenary presentation at the 2001 NASMHPD State Mental Health Research Conference (128). More recently, the process was recognized by the Annapolis Coalition on Behavioral Health Workforce Education of the as an "Innovative Educational Practices" and will be highlighted in a forthcoming special issue of Administration and Policy in Mental Health, a peer-reviewed journal that aims to improve the effectiveness of behavioral health services.

Commitments

As part of the evaluation, VDH commits to participate in the evaluation of the feasibility, validity, and reliability of the proposed co-occurring disorders performance measures with SAMHSA and the other grant sites. VDH agrees to participate in a cross-site evaluation, and we have budgeted for attendance of two persons to attend two meetings related to this purpose annually. VDH will collect and report outcomes using any new standards developed from this cross-site evaluation. VDH commits to comply with any changes in data collection requirements that occur during the project period.

Section D -- Literature Citations

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Section E -- Budget Justification/Existing Resources/Other Support

YEAR ONE

YEAR ONE Budget page 2

BUDGET YEAR TWO

YEAR TWO BUDGET page 2

BUDGET YEAR THREE

YEAR THREE Budget page 2

BUDGET YEAR FOUR

BUDGET YEAR FIVE

Section F -- Biographical Sketches/Job Descriptions

Biographical Sketches:	Beth Tanzman Linda Piasecki John Pandiani Zialogic Zialogic Letter of Support Kenneth Minkoff Christie Cline Dartmouth Psychiatric Research Center/West Institute Dartmouth PRC Letter of Support Jacques Runesha Muderhwa
Job Descriptions:	Integrated Treatment Program Specialist Program Evaluator Administrative Assistant Database Administrator Senior Research & Statistics Analyst

Beth Tanzman, MSW

Beth Tanzman has worked and consulted in public mental health systems for twelve years. She currently directs Vermont's Adult Community Mental Health Services. This includes community-based programs for individuals with severe and persistent mental illness, outpatient services, and emergency programs. Her duties include developing and administering budgets and contracts with ten local not-for-profit service agencies, overseeing the development and functioning of new and existing programs and services, and resolving complex client issues. In addition, Ms. Tanzman administers an acute care service responsible for managing the funds, performance contracts, and daily census for clients' psychiatric admissions to local general hospitals and oversees the utilization of Vermont State Hospital (VSH).

Ms. Tanzman is a key leader in Vermont's system change efforts. She developed Vermont's case rate provider reimbursement system, oversaw the development of new community capacities and a commensurate downsizing at VSH, designed and implemented a comprehensive quality management system for the community and inpatient service system, and assisted in the design of a new state-wide client-level information system.

Prior to working for the State of Vermont, Ms. Tanzman was a consultant and researcher with the Center for Community Change Through Housing and Support. Ms. Tanzman currently serves as Chair of the NASMHPD Adult Services Division and is active in the national Evidence-Based Practices implementation project.

Linda Piasecki (ADAP)

Education
M.A., experimental psychology, University of Vermont, Burlington, VT, 1996
B.A., philosophy, University of Maine, Orono, ME, 1971

Professional Experience

2000-present, Office of Alcohol and Drug Abuse Programs, Vermont Department of Health (Burlington, VT)

ADAP Operations Chief. Provides leadership, direction and supervision for the planning, development, implementation, and administration of information and reporting systems for the division. Provides coordination and supervision to assure smooth teamwork within and between units to produce single unified products used for program development, budgeting, performance analysis, and contracting. Works closely with Director on reports, strategies and policy discussions in emerging, high priority areas. Functions as an intermediary between ADAP and external treatment providers to assure that provider reporting and performance is in compliance with grant assurances. Oversees the federally funded research and evaluation projects and contracts done by the division (e.g. Needs Assessments and New Directions evaluation). Supervises a variety of ADAP staff, consultants and contractual services to support these projects. Assures that the research and evaluation activities support and further the goals and objectives of the division. Provides technical assistance to staff in statistical and research techniques and the application of quantitative measurement techniques. Generates grant proposals and/or collaborates with other division staff on proposals as necessary. Co-managed evaluation for $9 million federal statewide prevention project (State Incentive Cooperative Agreement) that was multi level (state, community and program) and collection of quantitative and qualitative data. Responsible for oversight, management and collaboration with federal project staff, state staff, research subcontractor, and coalition staff on evaluation and research activities. Responsible for assuring all deliverables (study protocols, annual and monthly progress reports, etc.) are met.

1993 to 1995, Agency for Human Services, Waterbury, VT

Systems Design and Development. Worked on systems development for comprehensive directory of all human services available throughout Vermont. Responsible for the design/development of a relational database system for outcome and process indicators for all departments in the Agency of Human Services. Provided trainings and technical assistance to all departments migrating to the system.

Honors and Associations

1997 Director's Award, Vermont Division of Alcohol and Drug Abuse Programs
Behavior Risk Factor Survey Advisory Committee, 1996

John A. Pandiani, Ph.D.
Chief of Research & Statistics

EDUCATION

University of Notre Dame	B.A.	1971	Sociology
University of Connecticut	M.A.	1973	Sociology
University of Connecticut	Ph.D.	1976	Sociology
State of Vermont	C.P.M.	1987	Certified Public Manager Program

EMPLOYMENT HISTORY

1975 - 1978 — Assistant Professor of Sociology
Middlebury College, Middlebury, Vermont

Designed and taught courses in Criminology, Sociology of Law, Technology and Social Change, and Social Psychology. Advised undergraduate students. Supervised senior thesis projects. Served on faculty committees dealing with research on human subjects.

1979 - 1982 — Director of Research and Evaluation
Washington County Mental Health, Montpelier, Vermont

Responsible for program evaluation and state and federally funded research projects (alcohol treatment effectiveness, monitoring client satisfaction).

1982 - Present — Chief of Research and Statistics
Department of Developmental and Mental Health Services, Waterbury, Vermont

Responsible for service system research and program evaluation in a statewide system of care for children and adults. This work has included a strong emphasis on using existing data resources, and extensive collaboration with service providers, consumers, and advocates.

OTHER AFFILIATIONS

1997 - Present — Research Director: The Bristol Observatory: A research and data analysis firm specializing in analyzing existing data bases while protecting the confidentiality of medical records and the personal privacy of people represented in electronic data bases.

2000 - Present — Member: NASMHPD President's Task Force on medical Records Confidentiality

2000 – Present Member: NASMHPD Technical Advisory Group on State Mental Health Profiles System

2000 – Present Faculty: University of South Florida Ethics in Research

SELECTED PUBLICATIONS

Pandiani JA and Glesne C (1992) Interpreting Divergent Results of Triangulated Research: A Review of Three Studies of Housing Needs of Adults with Psychiatric Diagnoses. *Sociological Practice Review*. Vol. 3, No. 2.

Pandiani JA and Girardi LM (June 1993) State Hospital Admission Diversion: A Re-Examination. *Hospital and Community Psychiatry*, Vol. 44, No 6.

Pandiani JA, Maynard A and Schacht LM (March 1994) Mathematical Modeling of Movement between Residential Placements: A Systems Analytic Approach to Understanding Systems of Care. *Journal of Child and Family Studies*.

Pandiani JA, Murtaugh M and Pierce J (Spring 1996) The Mental Health Care Reform Debate: A Content Analysis of Position Papers. *Journal of Mental Health Administration*, Vol. 23 (2).

Pandiani JA, Banks SM, and Gauvin LM (1997) A Global Measure of Access to Mental Health Services For a Managed Care Environment. *Journal of Mental Health Administration*, Vol. 24(3).

Pandiani JA, Banks SM, and Schacht LM (1997) An Examination of Variation in Long Term Community Tenure After Psychiatric Hospitalization in Eight States. *Evaluation and The Health Professions*.

Pandiani JA, Banks SM, and Schacht LM (1998) Personal Privacy vs. Public Accountability: A Technological Solution to an Ethical Dilemma. *The Journal of Behavioral Health Services and Research,* Vol. 25(4).

Banks SM, Pandiani JA, Gauvin LM, et al. (1998) Practice Patterns and Hospitalization Rates: A Statewide Program Evaluation. *Administration and Policy in Mental Health*, Vol. 26(1).

Pandiani JA, Banks SM, and Schacht LM (1998) Using Incarceration Rates to Measure Mental Health Program Performance. *The Journal of Behavioral Health Services & Research*, Vol. 25 (3).

Banks SM, and Pandiani JA (1998) The Utilization of State and General Hospitals for Inpatient Psychiatric Care. *American Journal of Public Health*, Vol. 88(3).

Banks SM, Pandiani JA, Schacht LM, and Gauvin LM (1999) A Risk Adjusted Measure of Hospitalization Rates For Evaluating Community Mental Health Program Performance. *Administration and Policy in Mental Health,* Vol. 26.

ZiaLogic is a professional corporation that offers behavioral health care systems an array of services to achieve systemic improvements in the delivery of care in the public and private sectors. The company uses a network of qualified contractors to work with systems of all complexities, including state (provincial) agencies, networks, counties and local agencies, programs, and provider associations.

One focus of ZiaLogic is on systems integration and integrated services for individuals with co-occurring mental health and substance use disorders to create "Dual Diagnosis Capable and Enhanced" behavioral health care systems. Co-occurring Disorders Services Enhancement Initiatives employ the Comprehensive Continuous Integrated Systems of Care Model (CCISC), and its associated "Twelve Step Program of Implementation", developed by Chief Consultant to ZiaLogic, Dr. Kenneth Minkoff. CCISC is recognized as a national consensus model for system design by SAMHSA and is referenced in the SAMHSA Report to Congress on Co-occurring Disorders (2002). This model is an adaptable approach to answering the very diverse and complex needs of systems of care in an organizing and developmentally appropriate manner.

Within the framework of the CCISC the basic approach ZiaLogic uses to facilitate systems development is consolidated into three Levels—System Readiness, Integrated Systems Planning and System Design, and Implementation Support. The activities associated with each level are attached.

Implementation of the CCISC occurs incrementally in complex systems over a period of several years. All efforts are grounded in Continuous Quality Improvement (CQI) processes. In most systems, different components of the system will be engaged at different levels, and, in fact, activities at Levels One, Two and Three will unfold and occur simultaneously and interactively, with all parts of the system informing the strategic advancement to the next steps.

ZIALOGIC Letter of Support

KENNETH MINKOFF, M.D. -- SENIOR SYSTEMS CHANGE CONSULTANT

SUMMARY OF PROFESSIONAL EXPERIENCE

ZIALOGIC, ALBUQUERQUE, NM
Chief Consultant/Systems Change Expert, April 2001 - Present
Dr. Minkoff , developer of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model and its associated "Twelve Step Program of Implementation," is a nationally known systems change expert. He is currently a consultant to numerous statewide consensus-building initiatives designed to create integrated systems of care for dual diagnosis of SPMI and substance disorder. Dr. Minkoff was Chair of the SAMHSA Managed Care Initiative Panel on Co-occurring Disorders in the mid-nineties, and co-authored the co-occurring disorder issues paper for the President's New Freedom Commission in 2002.

CHOATE HEALTH MANAGEMENT
Medical Director, 1996 - 2003
Responsible for medical leadership of a wide range of contracted relationships to provide management and program development services for behavioral health entities in numerous states, including Massachusetts, Vermont, Maine, and Tennessee. These programs included inpatient, partial hospital, outpatient, and crisis stabilization programs, for both adults and children, and for both mental health and substance abuse services.

ARBOUR-FULLER HOSPITAL, ARBOUR HEALTH SYSTEM
Medical Director, 1998 - 1999
Responsible for the medical leadership of an 82-bed psychiatric hospital, with adult, dual diagnosis, developmental disability, and adolescent inpatient programs, plus partial hospitalization.

CHOATE INTEGRATED BEHAVIORAL CARE
Medical Director, 1996 - 1997
Company-wide Medical Director of a national public/private psychiatric and addiction managed-care oriented provider system. Responsible for overall quality enhancement; standards; clinical policies and procedures; and the training, recruitment, and supervision of regional medical directors and programs.

CHOATE HEALTH SYSTEMS, INC.
Chief of Psychiatric Services, 1990 - 1995
Directed clinical services in a free-standing psychiatric hospital. Responsible for management and coordination of psychiatric and addiction inpatient unit, respite services, psychiatric day treatment, emergency services, addiction day treatment, and coordination with private and public providers.

CHOATE-SYMMES HEALTH SERVICES, INC.
Chief of Psychiatry, 1984 – 1990
Responsible for the management and coordination of a psychiatric and addiction inpatient unit, emergency services, addiction day treatment, consultation and liaison, and outpatient services.

SOMERVILLE MENTAL HEALTH CLINIC
Clinic Director, 1978 – 1984

Clinical and Administrative Director of a large community mental health clinic serving adults and children. Responsible for clinical leadership, program development, budgeting, grant writing, and staff supervision. *Medical Director, Day Treatment Center*, 1976-1978 Responsible for administration, coordination, clinical supervision, and case management in a full-time day treatment center program with 40 clients and 11 staff.

SKILLS

Board certified addiction psychiatrist with more than 17 years of experience in teaching, training, program development, clinical treatment, and system consultation in the area of co-occurring disorders. Experienced mental health and addiction clinician and administrator in public and private sector settings and in inpatient, residential, intensive outpatient, and outpatient treatment programs. Delivered more than 1,000 training sessions on his integrated model for the treatment of co-occurring disorders. Consultant to numerous States and several Canadian provinces. Expert in developing and implementing major systems change.

EDUCATION

UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE	M.D., 1972
HARVARD UNIVERSITY, CAMBRIDGE, MASSACHUSETTS	Pre-Med Studies 1969
HARVARD COLLEGE, CAMBRIDGE, MASSACHUSETTS	A.B., 1968

Postdoctoral Training*: Medical Internship, University of Pennsylvania; Psychiatric Internship, University of San Diego County, CA; Psychiatric Residency, University of California, San Diego*
Board Certifications*: American Board of Psychiatry and Neurology, with Special Qualifications in Addiction Psychiatry*

ACADEMIC APPOINTMENTS

From 1976 to the present, Dr. Minkoff has held academic appointments at Harvard Medical School in the Cambridge Hospital Department of Psychiatry. Since 1993, he has been Clinical Assistant Professor of Psychiatry.

SELECTED PRESENTATIONS & PUBLICATIONS

Since 1988, Dr. Minkoff has given more than 2,000 presentations in 45 States, as well as Puerto Rico, Canada, France, Holland, and New Zealand.

Dr. Minkoff served as a senior consultant on the development of the CCISC as a best practice model for enhancing services for individuals with psychiatric and substance disorders. His clients included state and regional systems in Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, and Washington.

Dr. Minkoff has written more than 40 journal articles, book chapters, and monographs on a broad range of topics in the area of co-occurring disorders for the American Journal of Psychiatry, American Journal on Addictions, Comprehensive Psychiatry, Disease Management & Health Outcomes, Hospital and Community Psychiatry, Innovations & Research, among others.

CHRISTIE A. CLINE, MD, MBA, PC – SENIOR SYSTEM STRATEGIC PLANNER

SUMMARY OF PROFESSIONAL EXPERIENCE

ZIALOGIC, ALBUQUERQUE, NM
President, April 2001- Present
President of ZiaLogic, a professional corporation that provides strategic planning and implementation consultation and support for behavioral health systems development, performs clinical and administrative trainings, provides technical assistance, and produces a variety of instruments and tools to support clinician development and system change. Dr. Cline partners with Kenneth Minkoff, M.D., a ZiaLogic Senior Systems Change Consultant, in the process of statewide co-occurring disorder program enhancement, curriculum development, and staff training. She has been instrumental in designing and implementing utilization of system change toolkit materials for development of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model. Dr. Cline has joined Dr. Minkoff in collaborating on CCISC implementation projects in Vermont, Winnipeg; Grand Rapids, MI; San Diego; Lynchburg, VA; Washington, DC; Worcester County, MD; Tampa, FL; Manitoba; and British Columbia.

NEW MEXICO DEPARTMENT OF HEALTH
Director, Office of Behavioral Health Policy, Research, and Technology Transfer, Behavioral Health Services Division; November 2001 – May 2003
Responsible for planning, management, and coordination of all activities (both within BHSD and collaborative with other State agencies), regarding development and evaluation of behavioral health policy and strategic implementation of best practices.

NEW MEXICO DEPARTMENT OF HEALTH
Project Director, Co-occurring Disorders Services Enhancement Initiative; July 2000 – May 2003
Developed consensus on the need for prioritization of co-occurring disorders for best practice system development, created a strategic plan for structured implementation using quality improvement processes to incentivize change within the Regional Care Coordination system, and, with Dr. Minkoff, developed a toolkit and curriculum for implementation, and provided train-the-trainer initiative and program technical assistance statewide.

NEW MEXICO DEPARTMENT OF HEALTH
Medical Director, Behavioral Health Services Division (State Behavioral Health Authority), July 1999 – May 2003
Responsible for establishing medical oversight of quality improvement, standards of care, best practice development, and interagency collaboration throughout the entire behavioral health system of New Mexico.

NEW MEXICO DEPARTMENT OF HEALTH
Project Director, New Mexico Pharmacotherapy Initiative for the Treatment of Schizophrenia ; January 1999 – May 2003
Adapted TMAP to New Mexico, created implementation plan involving consumers, and developed structures for implementation statewide, involving ongoing support to physicians and nurses in all regions.

SKILLS

Areas of expertise include combination of masters in business administration with a specialization in complex systemic strategic planning and development, along with clinical and administrative background in adult psychiatry (medical specialty) and public behavioral healthcare systems planning and development.

EDUCATION

MEDICAL COLLEGE OF VIRGINIA, VIRGINIA COMMONWEALTH UNIVERSITY
M.D., 1995
GEORGETOWN UNIVERSITY, GRADUATE SCHOOL OF BUSINESS
M.B.A., 1989
SOUTHWEST TEXAS STATE UNIVERSITY, SAN MARCOS, TEXAS
M.S., Biology, 1984
SOUTHWEST TEXAS STATE UNIVERSITY, SAN MARCOS, TEXAS
B.S., Biology, 1981

Postdoctoral Training*: University of New Mexico Hospitals – Chief Resident in Psychiatry (1998 - 1999); Resident in Psychiatry (1996 – 1998); Intern in Psychiatry (1995 – 1996)*
Board Certifications*: Diplomate --American Board of Psychiatry and Neurology, Inc., a member Board of the American Board of Medical Specialties*

SELECTED PRESENTATIONS

Implementation of the "Comprehensive Continuous Integrated Systems of Care Model in Multiple State Systems" Statewide System Integration Conference, Portland, OR, (May, 2003).

Implementation of the "Comprehensive Continuous Integrated Systems of Care Model for Individuals with Co-occurring Psychiatric and Substance Disorders - the New Mexico Co-occurring Disorders Services Enhancement Initiative," presented at "Changing the World: Strategies for Systems Change to Implement Services for Individuals with Co-occurring Psychiatric and Substance Disorders" conference, Santa Fe, NM (April 2002).

MONOGRAPHS AND PUBLICATIONS:
Minkoff, K and Cline, C. CODECAT™ (Version 1) Co-occurring Disorders Educational Competency Assessment Tool/Clinician Core Competencies for Co-occurring Psychiatric and Substance Disorders, ZiaLogic 2001.

Minkoff, K and Cline, C. COMPASS™ (Version 1) Comorbidity Program Audit and Self-Survey for Behavioral Health Services/Adult and Adolescent Program Audit Tool for Dual Diagnosis Capability, ZiaLogic 2001.

Minkoff, K and Cline, C. CO-FIT 100™ (Version 1) The CCISC Outcome Fidelity and Implementation Tool: Systems Measurement Tool For The Comprehensive Continuous Integrated Systems Of Care Model For Integration Of Psychiatric And Substance Disorder Services, ZiaLogic 2002.

NEW HAMPSHIRE – DARTMOUTH PSYCHIATRIC RESEARCH CENTER

The New Hampshire-Dartmouth Psychiatric Research Center (PRC) was established in 1987 as a public-academic liaison involving the New Hampshire Division of Behavioral Health and the Dartmouth Medical School. Initial research in New Hampshire focused on integrating case management and substance abuse services, and on integrating vocational and mental health services. In the early 1990's, the PRC expanded beyond New Hampshire and replicated its earlier findings through research in urban settings in Connecticut and Washington, DC. In the late 1990's, the PRC developed new research areas; further developed existing programs; enhanced economics, statistics, and data management capacity; developed a greater number of research collaborations around the country; and enhanced junior faculty support and training.

Currently, PRC staff are involved in various capacities (e.g., investigators, consultants, trainers) in many states outside of New Hampshire, including Vermont, Rhode Island, Connecticut, New York, Massachusetts, Maryland, Washington, North Carolina, South Carolina, Texas, Missouri, Illinois, Ohio, California, Oregon and Washington, DC.

Current areas of research are:

- Implementation of Evidence Based Practices
- Vocational rehabilitation/supported employment
- Services for homeless persons
- Integrated treatment of co-occurring substance abuse
- Services for the elderly
- Trauma and post-traumatic stress disorder
- Infectious diseases (including HIV and hepatitis)
- Methodology of services research

The PRC conducts interdisciplinary research on services for individuals who have severe mental illness (SMI), primarily schizophrenia spectrum and bipolar disorders. The PRC specializes in developing effective interventions under research conditions, then translating these interventions into actual mental health service practices and evaluating their effectiveness in routine practice settings. PRC research incorporates multiple scientific perspectives, such as clinical, economic, and ethnographic. The PRC works with efficacy and services researchers to address the needs of multiple stakeholders through effectiveness research in routine practice settings.

Since 1987 the NH-Dartmouth Psychiatric Research Center has studied mental health services and helped providers establish programs based on evidence gained from research. The West Institute was founded in 2000 thanks to a generous gift from the West Family Foundation. The Institute promotes the implementation of Evidence-Based Practices (EBPs) in public mental health systems across the country while studying the process of implementation.

Evidence-Based Practices
Research efforts show that certain clinical practices work to improve the lives of adults with severe mental illness. These practices should be available to all persons with severe mental illness.

Currently, the six identified Evidence-Based Practices are: assertive community treatment, integrated dual disorders treatment, supported employment, effective medication practices, family psycho education and illness management and recovery.

Training
Mental health system leaders express an urgent need for effective staff training. The West Institute provides training that complements and extends implementation resource material.

Mentoring
Based on strong evidence for the effectiveness of mentoring, the institute builds ongoing one-on-one consultation to provider staff into our implementation packages.

Information Exchange
Colleagues in service systems, federal agencies and academic centers attest to the NH-Dartmouth Psychiatric Research Center's success in bridging the gap between research and practice. The West Institute has participated in the establishment of regional implementation centers.

West Institute Implementation Services
The goal of our services is to assist mental health systems and agencies to successfully implement EBPs in high fidelity and sustainable ways.

The West Institute offers services that describe research findings, comprehensively illustrate service models, and provide skills training and education to implement the practice effectively. The West Institute also supplies consultation on methods and systems to support and sustain the practice in viable ways.

PRC Letter of Support

JACQUES RUNESHA MUDERHWA
35 Franklin Square, Burlington, VT 05401, USA
Tel & Fax: (802) 865-3371 (H); E-mail: JacquesRunesha@aol.com

EDUCATION

POST-GRADUATE STUDIES

Child Survival and Nutritional Surveillance, Hubert Humphrey Fellowship Program, School of Public Health & Tropical Medicine, New Orleans, Louisiana, USA, 07/1991.

MASTER OF PUBLIC HEALTH

International health with concentration in Nutrition, School of Public Health & Tropical Medicine, New Orleans, Louisiana, USA, 07/1986.

BACHELOR OF SCIENCE

Nutrition & Dietetic, University of Zaire, Institut Superieur de Techniques Medicales, Kinshasa, Democratic Republic of CONGO (Zaire), 02/1981.

PROFESSIONAL EXPERIENCE

07/98-12/00:	Health Program Coordinator, WORLD VISION, Republic of Mali, West Africa
04/97-07/98:	Child Survival Project Coordinator, WORLD VISION, Republic of Mali, West Africa
09/94-12/95:	Child Survival Project Coordinator, AFRICARE, Republic of Niger, West Africa
07/92-07/94:	Chief of Party, Vitamin A Project, UNDP-FAO, Republic of Niger, West Africa
06/86-07/91:	Chief of Program: Nutritional Surveillance and Breast-feeding, National Nutrition Planning Center (CEPLANUT), Kinshasa, Democratic Republic of CONGO, Central Africa
08/82-07/84:	Chief Nutritionist: CEPLANUT/USAID Nutrition Project, Bandundu, Democratic Republic of CONGO, Central Africa
06/81-07/82:	Supervisor: Nutritional Rehabilitation Center, CEPLANUT, Kinshasa, Democratic Republic of CONGO, Central Africa

CONSULTANCIES

12/29/96-01/10/97:	Technical reviewer of child survival applications submitted to USAID's Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation, USA
02/02/96-02/27/96:	Consultant, US Peace Corps/Niger: wrote the child survival project addressing nutritional education, Niamey/NIGER

03/09/92-05/30/92: Consultant, Academy for Educational Development (AED), Nutrition Communication Project: trained health personnel, Bamako & Segou/MALI

09/16/91-12/20/91: Consultant, CHP International: trained US Peace Corps volunteers in Public Health and Nutrition, Thies/SENEGAL

07/16/91-09/13/91: Consultant, Academy for Educational Development (AED) Nutrition Communication Project: as guest speaker, prepared the conference for francophone African countries on optimal infant feeding & child survival, Washington, DC & Lome/TOGO

ADDITIONAL EXPERIENCE

03/19-03/94: Attended workshop for FAO Nutrition Experts on Micronutrients deficiency strategies for developing countries, Harare, ZIMBABWE

08/09-12/93: As presenter, attended West African conference on Vitamin A deficiency towards development of policies and strategies, Accra, GHANA

06/04-15/90: Attended workshop for Central African countries on Food & Nutrition Surveillance, WHO/UNICEF/FAO, Kinshasa, Democratic Republic of CONGO

06/12-16/89: Attended regional seminar for French-speaking African countries on infant feeding, International Baby Food Action Network (IBFAN), Lome, TOGO

06/15-30/85: Attended a course on IEC for health and family planning programs, University of California, Santa Cruz, USA

ADDITIONAL SKILLS

Computer skills: Work, Excel, WordPerfect, Dbase, Lotus 123, Epi Info softwares.

Language: speak and write French, English, Swahili, Lingala, and Kikongo.

HONORS

Certificate of achievement in a technical cooperation program under the program of the Agency for International Development of the Government of the United States of America from 1984 to 1986.

Honorary Citizen of New Orleans, October 1990.

Certificate of the successful completion of a one-year program of graduate study and professional development as a Participant in the Hubert H. Humphrey Fellowship Program, July 1991.

Integrated Treatment Program Specialists

Job Description: These two positions will be responsible for co-facilitating the implementation of integrated treatment statewide through a collaborative partnership with DDMHS and ADAP. The program specialists will be responsible for the day-to-day staffing and planning of the State Policy and Operations Team and the Regional Leader/Trainer Cohorts. The Program Specialists will work under the direct supervision of the DDMHS Director of Adult Community Mental Health Services with additional supervision from the ADAP Director of Operations. The program specialists will perform a variety of complex administrative planning and evaluation tasks and will be skilled in group facilitation and nominal group decision-making techniques.

Examples of Work:

- Orients and educates participants in the planning process and grant activities
- Coordinates communication between planning groups
- Prepares written summaries of planning group meetings, proposals, or other related material
- Prepares written promotional material for conferences and workshops
- Coordinates logistical support for all activities in this initiative
- Schedules training conferences and consultant visits and coordinates the needs for technical assistance across the state
- Schedules and facilitates regular meetings of the State Policy and Operations Team and the Regional Leader/Trainer Cohorts
- Works with evaluation partners and other program staff to develop evaluation materials
- Assembles and presents outcome data related to the planning process
- Participate in planning and writing of grant activities
- Maintains an ongoing dialogue with a wide spectrum of consumers, providers, civic organizations, and state agencies about the integrated treatment planning processes and needs
- Promotes the success of the project through the performance of other duties to be identified by supervisor and/or in conjunction with the State Policy and Operations Team
- Works closely with the participating project service providers on the development of local action plans and the maintenance of the computer list serve.
- Supervises the work of the administrative assistance associated with this project

Minimum Qualifications: Master's degree in rehabilitation counseling, counseling, psychology, social work, or related human services area and 2 to 3 years of relevant experience in substance abuse and /or community mental health services or related rehabilitation services. Certification in Drug and Alcohol programming preferred. Ability to take initiative, work independently, identify and resolve problems, and overcome obstacles. Must possess excellent communication and interpersonal skills including providing training and consultation to groups and individuals, a solid ability to work well with others and as a team member. Must possess knowledge about integrated dual disorder treatment. Previous experience with providing integrated mental health and substance abuse treatment is desired.

Program Evaluator

Job Description: This position will be responsible for evaluating the implementation of integrated treatment for individuals with co-occurring disorders served in Vermont's DMH and ADAP adult outpatient programs. The evaluator will be tracking action plans and milestone achievements, making qualitative observations on systemic barriers, rating fidelity of program practices to nationally recognized best practice principles, and ensuring collection of project-specific quantitative data. In this role, he/she will providing ongoing feedback to all participating stakeholders, and in particular the program specialists, the database administrator and the data analyst. The evaluator will work under the direct supervision of the DDMHS Director of Adult Community Mental Health Services with additional supervision from the ADAP Director of Operations.

Examples of work:

- Attend and document all meetings pertinent to the management of the project.
- Spend time at each implementing site going to team meetings, meeting with the program leader and practitioners, meeting with local family and consumer groups, and making observations about barriers to implementation and strategies that are being used to try to overcome those barriers.
- Assess co-occurring treatment fidelity ratings at baseline and thereafter.
- Write site-specific fidelity reports following a standardized format.
- Follow the research protocol to document implementation barriers and strategies as they relate to fidelity. This includes collecting information from consumers, families, advocates, clinicians, and program leaders.
- Enter and manage qualitative data using designated software.
- Participate in national research initiatives relating to National Evidence Based Practices Demonstration Project through involvement in conference calls to further develop evaluation protocols.
- Work with the data analyst and the database administrator to evaluate the outcome tracking system.
- Devise new evaluation and measurement techniques and solutions for non-standard problems. Collect or oversee collection of project-specific data which serves as the basis for research.

Qualifications:

Minimum Qualifications: Master's degree in rehabilitation counseling, counseling, psychology, social work, or related human services area and 2 to 3 years of relevant experience in community mental health services or related rehabilitation services; or bachelor's degree with similar training and 4 to 5 years of relevant experience in community mental health services or rehabilitation services; or the equivalent. The evaluator must have familiarity with qualitative and quantitative methods for program evaluation, must be able to work independently and must be able to travel on regular basis. Familiarity with integrated treatment for individuals with co-occurring disorders and/or system change models is desired.

Administrative Assistant

Class Definition:
Administrative work as an assistant to a manager, unit or program chief, or with direct responsibility for a specific assigned program or function. While actual duties may vary, positions in this class are characterized by work in a technical or specialized field, decision making with little concurrent supervisory review, and accountability for results. The role differs from higher level administrative assistants by a more limited program or functional area, and less impact upon total department activities. Assignments may generally be characterized as a first level administrative role with clearly indicated functional and authority dimensions. Assigned duties may include employee supervision. Work is performed under the direction of an administrative superior.

Examples of Work:
As delegated, may perform assigned tasks of a technical nature requiring independent action and full accountability for program results. Examples include but are not limited to managing support services such as budget, personnel, purchasing or space and communications needs for a board, director or program administrator; administering a licensing or service application procedure requiring analysis of data and an approval or disapproval decision; receiving requests and complaints from consumers and taking substantive action(s) to resolve or alleviate the problem; and serving as coordinator of various support services at a department or institutional level. Duties frequently may include staff supervision with delegated authority for hiring, training, assigning and evaluating work, and disciplining lower level employees. May prepare a variety of fiscal, statistical, or narrative reports. May serve as acting head or represent unit in supervisor's absence. May personally perform complex and confidential secretarial related duties. May develop and implement program procedures. Performs related work as required.

Minimum Qualifications:
Associate's degree in business technology, secretarial science or office management; OR High school graduation or equivalent and three years of office clerical experience. Completion of a one-year vocational/technical training program in business and office occupations or related area may be substituted for one year of the work experience. College coursework may be substituted for the work experience on a semester for six months basis.

Database Administrator

Job Description: This position is responsible for evaluating state databases and creating shared database for DMH and ADAP, including the development of new database collection capacity. The database administrator will be responsible for administering and maintaining a Microsoft SQL Server database. The ideal candidate will have extensive knowledge of Microsoft SQL (7 or 2000), experience with authoring stored procedures and triggers, and experience with business analysis, Web development and data warehousing. Familiarity with a UML or other modeling protocol is a plus. Work is performed under the general supervision of the DDMHS Research and Statistics Director.

Examples of Work:

- Analyze user needs and prioritizes requests for new or enhanced computer applications.
- Design capacity plans based on DMH and ADAP needs and current resources.
- Work closely with the project evaluator and data analyst to ensure the database can support reporting requirements of the project.
- Create proposals to provide step-by-step process for implementing a new or revised database service.
- Research, evaluate, and recommend database management systems, software, compilers, and utilities.
- Develop detailed specifications (functional, system, and program) using tested methods.
- Conduct research to keep current on all technologies and methods useful to operations management and for system development. Performs related duties as required.
- Construct specifications for programmers and data base administrators.

Minimum Qualifications:
Bachelor's degree in computer science AND two years experience in programming, data base administration or systems analysis; OR Associate's degree in computer science or college-level coursework that includes 15 computer science credits AND four years experience in programming, data base administration, or systems analysis; OR Six years experience in programming, data base administration, or systems analysis.

Senior Research & Statistics Analyst

Job Description: This position is responsible for all quantitative data analysis for evaluating the implementation of integrated treatment for individuals with co-occurring disorders served in Vermont's DMH and ADAP adult outpatient programs. This will involve working with existing behavioral administrative datasets, other human services administrative datasets and assisting in the development of Vermont's capacity to collect and report on key PPG measures. General work will be under the supervision of the project directors with analysis of data under the supervision of the DDMHS Research and Statistics Director. The data analyst will be able to conceptualize data needs and means of attainment for both existing and potential programs, working closely with the evaluator and the database administrator in this task.

Examples of Work:

- Identify and analyze program and operational needs for information and research.
- Plan and conduct complex research and evaluation projects.
- Identify database infrastructure requirements in order to answer stakeholder questions and respond to national PPG reporting requirements.
- Conduct analyses on project-specific monitoring tools collected by the evaluator.
- Develop research designs and data analysis methods for complex or difficult projects, or those that go beyond existing approaches.
- Develop weekly short reports providing ongoing feedback to the full community of stakeholders.
- Conduct analyses for reporting national PPG measures as required.
- Report findings for inclusion in annual implementation progress reports.

Minimum Qualifications:

Master's degree in rehabilitation counseling, counseling, psychology, social work, or research methods and 2 to 3 years at a technical or professional level in quantitative research, statistics, or program evaluation, including one at a professional level. The data analyst must develop an understanding of the statewide ADAP and DMH provider system, be able to coordinate and successfully conclude major analytical projects, and be able to maintain and apply state of the art skills.

Section G -- Confidentiality/SAMHSA Participant Protections

1. Protection from Potential Risks: There are no known risks from participating in or evaluating the proposed activities. In fact, it is likely that participants would benefit substantially from the new skills and knowledge they will be exposed to. Participation in project activities will be entirely voluntary, and all personal identifying information that might be documented in this project will only be accessible to project staff directly involved in completing grant activities.

Professional staff who are involved in the State Policy and Operations Team or the listening focus groups may be concerned that criticisms of the treatment system might jeopardize their employment. Consumers or families involved in these same groups may also fear that their access to services might be limited if they criticize the treatment providers they currently work with. In both cases, however, there is very little likelihood that responses could be tied back to individual practitioners, and the purpose of the focus groups is to solicit critical feedback. A consent form (see Appendix 2) will be used with participants to fully explain the project and potential risks and will be updated to be fully HIPPA compliant. All staff associated with this project will receive additional training regarding protection of human subjects and sign additional confidentiality agreements, and all research methods will be reviewed by the state Agency of Human Services IRB.

2. Fair Selection of Participants: Participation in project activities will be entirely voluntary; therefore, no one will be excluded from participating. This project represents a broad-based planning and training initiative and will include consumer leaders, family members, advocates and administrative and treatment professionals from diverse backgrounds (see section B and C). Individuals with mental and/or substance disorders are included because of their ability to speak about what changes need to occur in the system based on personal experience. The population will not include homeless youth, foster children, or children of substance abusers/ Parents of children involved in the system will likely be involved. A few individuals involved may happen to be pregnant, but that has no bearing on their inclusion or participation.

3. Absence of Coercion: Participation will be invited and entirely voluntary, without coercion. Incentive funds will be given to provider agencies to support indirect time spent on activities, but this money will not go to individual staff who are participating.

4. Appropriate Data Collection: Data will be collected from a broad array of programs and stakeholders (consumers, family members, treatment and prevention providers, state administrators) and will focus on 1) the ability of Vermont programs to provided integrated services, 2) barriers to developed integrated services, 3) progress towards developing integrated services. Part of the data collection will focus on assessing the ability of programs to identify persons with co-occurring, as well as the outcomes persons with co-occurring disorders are achieving. This data collected on individuals involved in the Vermont prevention and treatment system will be a “limited data set” as defined at 45 CFR 164.514(e). This data may be extracted from protected health information, but will exclude the following direct identifiers of individuals:

- Names;
- Postal address information, other than town or city, State, and zip code;
- Telephone numbers;
- Fax numbers;
- Electronic mail addresses;
- Social security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers, including finger and voice prints; and
- Full face photographic images and any comparable images.

The evaluation component of this project will only use any protected health information provided by Client for the purpose of evaluating mental health and substance abuse program performance. Data analyses or reports produced by this project will not include individually identifiable information. This project will not disclose any information in a manner that would violate the requirements of the HIPAA Privacy Rule. This project will not identify the individuals who are the subject of this evaluation.

A full description of data collection procedures is described in Section C.

5. Privacy and Confidentiality: Participant acknowledgements in any public or written documentation or mailing list will be voluntary. A full description of who and how data will be collected is described in section C. This data collected on individuals involved in the Vermont prevention and treatment system will be a "limited data set" as defined at 45 CFR 164.514(e). This data may be extracted from protected health information, but will exclude direct identifiers of individuals (see #4). The evaluation component of this project will only use any protected health information provided by Client for the purpose of evaluating mental health and substance abuse program performance. Data analyses or reports produced by this project will not include individually identifiable information. This project will not disclose any information in a manner that would violate the requirements of the HIPAA Privacy Rule. This project will not identify the individuals who are the subject of this evaluation.

6. Adequate consent procedures: Participants are free to participate or not, as they desire. Participants will be given information on the Vermont Integrated Services Project and a consent form. Information on the consent form will include: 1) explanation that participation is voluntary and that participants may withdraw anytime, 2) the purpose of this study, 3) benefits from participating in this study, 4) description of study, 5) what will happen if individuals choose not to participate in this study, 6) the risks involved with being enrolled in this study, 7) protections for confidentiality, 8) whom to call with questions about this study, 9) explanation that there are no costs of the study for participants, and participants will not be paid, and 10) what

happens if a person gets sick or hurt from participating in this study. A sample consent form for participants is also included in Appendix 2. This consent form will have to be updated to meet HIPAA standards and the regulations based on 45 CFR 46.101(b)(1).

7. Risk-Benefit Discussion: Given that this project focuses on helping prevention and treatment programs develop integrated services, the participants/subjects are the mental health staff themselves and those stakeholders invited to share concerns and recommendations about the development of integrated services. Thus, the risks involved in this study are very low. Most of the grant activities are no higher in level of risk than everyday work activities. Professional staff who are involved in the State Policy and Operations Team or the focus groups may be concerned that criticisms of the treatment system might jeopardize their employment. Consumers or families involved in these same groups may also fear that their access to services might be limited if they criticize the treatment providers they currently work with. In both cases, however, there is very little likelihood that responses could be tied back to individual practitioners, and the purpose of the focus groups is to solicit critical feedback. A consent form (see Appendix 2) will be used with participants to fully explain the project and potential risks and will be updated to be fully HIPPA compliant.

As budgets for treatment and prevention services are decreasing, the need to provide quality services at a reasonable cost becomes increasingly critical. Developing integrated services within the existing Vermont system is one way to assure that dollars are well spent and that consumers and their families are receiving proper treatment. This project strives to find successful ways to develop integrated services so that the knowledge attained can then be used by other states to do the same.

Appendix 1: Letters of Commitment/Support

1. Charlie Smith, Secretary of Agency of Human Services
2. Department of Developmental and Mental Health Services
3. Department of Health
4. Department of Corrections
5. NAMI-VT
6. Vermont Psychiatric Survivors
7. Friends of Recovery – Vermont
8. Clara Martin Center
9. Counseling Services of Addison County
10. Howard Center for Human Services
11. Health Care and Rehabilitative Services
12. Lamoille County Mental Health Services
13. Northwest Counseling and Support Services
14. Rutland Mental Health Services
15. Washington County Mental Health
16. Vermont Association for Mental Health
17. Northern Counties Health Care
18. Community Rehabilitation and Emergency Services
19. Upper Valley Substance Abuse Foundation
20. Community Health Center of Burlington
21. Justice Works! Windsor County Court Diversion Programs
22. New Hampshire-Dartmouth Psychiatric Research Center
23. ZiaLogic

Appendix 2: Sample Consent Forms

Consent to Participate in Evaluation

CONSENT TO PARTICIPATE IN EVALUATION

Project Title: Vermont Integrated Services Project

Primary Evaluator: _____

Sponsor: Substance Abuse and Mental Health Services Administration

You are being asked to provide feedback about the needs of persons with co-occurring mental health and substance disorders. Your participation is voluntary. Your decision whether or not to participate will have no effect on your job status or your ability to receive services. Please ask questions if there is anything you do not understand.

What is the purpose of this study?

The purpose of the study is to understand the process of developing integrated services for persons with co-occurring disorders in Vermont. This project seeks to understand 1) what are the support and treatment needs of persons with co-occurring disorders? 2) what barriers prevent persons with co-occurring disorders from getting the support and treatment they need? And 3) what activities funded by the grant project helped with the development of appropriate support and treatment for persons with co-occurring disorders?

Are there any benefits from participating in this study?

We hope to gather information regarding the development of integrated services that may help people who are trying to develop integrated services in our state and in other states in the future.

What does this study involve?

As part of the standard procedures of this project, you will participate in one or more meetings to discuss issues relating to co-occurring disorders. We will ask you for your opinion and feedback on the following questions: 1) what are the support and treatment needs of persons with co-occurring disorders? 2) what barriers prevent persons with co-occurring disorders from getting the support and treatment they need? And 3) what activities funded by the grant project helped with the development of appropriate support and treatment for persons with co-occurring disorders? After an initial meeting, we may ask to you meet with us again to let you know how the project has progressed and ask you if you feel that anything has changed for better or worse. Your feedback will be written down on paper, but your name will not be recorded with the feedback that you provide us.

What are the risks involved with being enrolled in this study?

There is minimal risk involved in participation, as your name will not appear on anything that is shared with the project staff. The evaluator conducting the project has no authority over your position or the organization providing you with services. When overall feedback on co-occurring disorders is recorded, it will be as compiled data and your responses will be integrated with others in similar positions across the state. You should be aware however, that there is a small group of people in your position being interviewed in your state.

Other important items you should know:

• Withdrawal from the study: You may choose to stop your participation in this evaluation project. Your decision to stop your participation will have no effect on your job status or your ability to receive services.

• New Information: To the best of our ability, any significant new findings during this evaluation project will be made known to you. You can then decide if you want to continue in this project.

• Confidentiality: Every effort will be taken to protect the names of the participants in this study. Your name will not be transcribed onto the records of your feedback. The transcript will then be combined with the comments and observations of other people involved in the project, and it will be used to understand the process and outcomes of developing integrated treatment in Vermont. However, there is no guarantee that the information cannot be obtained by legal process or court order.

If you give us information about the abuse/neglect of a minor or incapacitated adult or make threat of harm to self or others, we may have to report this information to the appropriate individuals.

Who should you call with questions about this study?

Questions about this project may be directed to the investigator in charge of the study: _____ and John Pandiani at (800) 212-4677 during normal working hours.

What about the costs of this study?

There are no costs involved with participation in this project.

Will you be paid to participate in this study?

You will not be paid for participation.

What happens if you get sick or hurt from participating in this study?

DDMHS POLICY: It is VDH policy that if you are injured or become ill as a result of research procedures, we will assist you (if necessary) in seeking medical treatment but we will not pay for this treatment. If you have any questions about the legal responsibility of VDH, you may call Wendy Beinner at (802) 241-2604 Monday through Friday between the hours of 8:00 am and 5:00 pm.

CONSENT

I have read the above information about the Vermont Integrated Services Project, and have been given an opportunity to ask questions. I agree to participate in this evaluation project and I have been given a copy of this consent document for my own records.

SIGNATURES:

_____ _____

Participant Signature and Date Evaluator Signature and Date

Appendix 3: Data Collection Instruments/Interview Protocols

COMPASS
COFIT

ASSURANCES

Certifications

Drug Free Workplace Certification

Disclosures of Lobbying Activities: N/A

Checklist